

106TH CONGRESS
1ST SESSION

H. R. 2824

To amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 9, 1999

Mr. COBURN (for himself, Mr. SHADEGG, Mr. COOKSEY, Mr. HILLEARY, Mr. VITTER, Mrs. EMERSON, Mr. GILLMOR, Mr. REGULA, Mrs. CUBIN, Mr. GRAHAM, Mr. CUNNINGHAM, and Mr. WELDON of Florida) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Education and the Workforce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—This Act may be cited as the
3 “Health Care Quality and Choice Act of 1999”.

4 (b) TABLE OF CONTENTS.—The table of contents of
5 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—IMPROVING MANAGED CARE

Subtitle A—Grievances and Appeals

Sec. 101. Utilization review activities.
Sec. 102. Internal appeals procedures.
Sec. 103. External appeals procedures.
Sec. 104. Establishment of a grievance process.

Subtitle B—Access to Care

Sec. 111. Consumer choice option.
Sec. 112. Choice of health care professional.
Sec. 113. Access to emergency care.
Sec. 114. Access to specialty care.
Sec. 115. Access to obstetrical and gynecological care.
Sec. 116. Access to pediatric care.
Sec. 117. Continuity of care.
Sec. 118. Network adequacy.
Sec. 119. Access to experimental or investigational prescription drugs.

Subtitle C—Access to Information

Sec. 121. Patient access to information.

Subtitle D—Protecting the Doctor-Patient Relationship

Sec. 131. Prohibition of interference with certain medical communications.
Sec. 132. Prohibition of discrimination against providers based on licensure.
Sec. 133. Prohibition against improper incentive arrangements.
Sec. 134. Payment of clean claims.

Subtitle E—Definitions

Sec. 151. Definitions.
Sec. 152. Preemption; State flexibility; construction.
Sec. 153. Exclusions.
Sec. 154. Coverage of limited scope plans.
Sec. 155. Regulations; coordination; application under different laws.

**TITLE II—APPLICATION OF QUALITY STANDARDS TO GROUP
HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER
THE PUBLIC HEALTH SERVICE ACT**

Sec. 201. Application to group health plans and group health insurance coverage.

Sec. 301. Application of patient protection standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.

Sec. 302. ERISA preemption not to apply to certain actions involving health insurance policyholders.

Sec. 303. Availability of binding arbitration.

Sec. 401. Amendments to the Internal Revenue Code of 1986.

Sec. 501. Effective dates.

Sec. 502. Coordination in implementation.

Sec. 601. Health care paperwork simplification.

Sec. 602. Protection for certain information.

Sec. 603. Medicare competitive pricing demonstration project.

3 Subtitle A—Grievance and Appeals

5 (a) COMPLIANCE WITH REQUIREMENTS.—

•HR 2824 IH

1 (2) USE OF OUTSIDE AGENTS.—Nothing in this
2 section shall be construed as preventing a group
3 health plan or health insurance issuer from arrang-
4 ing through a contract or otherwise for persons or
5 entities to conduct utilization review activities on be-
6 half of the plan or issuer, so long as such activities
7 are conducted in accordance with a utilization review
8 program that meets the requirements of this section.

9 (3) UTILIZATION REVIEW DEFINED.—For pur-
10 poses of this section, the terms “utilization review”
11 and “utilization review activities” mean procedures
12 used to monitor or evaluate the use or coverage,
13 clinical necessity, appropriateness, efficacy, or effi-
14 ciency of health care services, procedures or settings,
15 and includes prospective review, concurrent review,
16 second opinions, case management, discharge plan-
17 ning, or retrospective review.

18 (b) WRITTEN POLICIES AND CRITERIA.—

19 (1) WRITTEN POLICIES.—A utilization review
20 program shall be conducted consistent with written
21 policies and procedures that govern all aspects of the
22 program.

23 (2) USE OF WRITTEN CRITERIA.—

24 (A) IN GENERAL.—Such a program shall
25 utilize written clinical review criteria developed

1 with input from a range of appropriate prac-
2 ticing physicians, as determined by the plan,
3 pursuant to the program. Such criteria shall in-
4 clude written clinical review criteria that are
5 based on valid clinical evidence where available
6 and that are directed specifically at meeting the
7 needs of at-risk populations and covered indi-
8 viduals with chronic conditions or severe ill-
9 nesses, including gender-specific criteria and pe-
10 diatric-specific criteria where available and ap-
11 propriate.

12 (B) CONTINUING USE OF STANDARDS IN
13 RETROSPECTIVE REVIEW.—If a health care
14 service has been specifically pre-authorized or
15 approved for an enrollee under such a program,
16 the program shall not, pursuant to retrospective
17 review, revise or modify the specific standards,
18 criteria, or procedures used for the utilization
19 review for procedures, treatment, and services
20 delivered to the enrollee during the same course
21 of treatment.

22 (C) REVIEW OF SAMPLE OF CLAIMS DENI-
23 ALS.—Such a program shall provide for an
24 evaluation of the clinical appropriateness of at
25 least a sample of denials of claims for benefits.

1 (c) CONDUCT OF PROGRAM ACTIVITIES.—

2 (1) ADMINISTRATION BY HEALTH CARE PRO-
3 FESSSIONALS.—A utilization review program shall be
4 administered by appropriate physician specialists
5 who shall oversee review decisions.

6 (2) USE OF QUALIFIED, INDEPENDENT PER-
7 SONNEL.—

8 (A) IN GENERAL.—A utilization review
9 program shall provide for the conduct of utiliza-
10 tion review activities only through personnel
11 who are qualified and have received appropriate
12 training in the conduct of such activities under
13 the program.

14 (B) PROHIBITION OF CONTINGENT COM-
15 PENSATION ARRANGEMENTS.—Such a program
16 shall not, with respect to utilization review ac-
17 tivities, permit or provide compensation or any-
18 thing of value to its employees, agents, or con-
19 tractors in a manner that encourages denials of
20 claims for benefits. This subparagraph shall not
21 preclude any capitation arrangements between
22 plans and providers.

23 (C) PROHIBITION OF CONFLICTS.—Such a
24 program shall not permit a health care profes-
25 sional who is providing health care services to

1 an individual to perform utilization review ac-
2 tivities in connection with the health care serv-
3 ices being provided to the individual.

4 (3) ACCESSIBILITY OF REVIEW.—Such a pro-
5 gram shall provide that appropriate personnel per-
6 forming utilization review activities under the pro-
7 gram, including the utilization review administrator,
8 are reasonably accessible by toll-free telephone dur-
9 ing normal business hours to discuss patient care
10 and allow response to telephone requests, and that
11 appropriate provision is made to receive and respond
12 promptly to calls received during other hours.

13 (4) LIMITS ON FREQUENCY.—Such a program
14 shall not provide for the performance of utilization
15 review activities with respect to a class of services
16 furnished to an individual more frequently than is
17 reasonably required to assess whether the services
18 under review are medically necessary or appropriate.

19 (d) DEADLINE FOR DETERMINATIONS.—

20 (1) PRIOR AUTHORIZATION SERVICES.—

21 (A) IN GENERAL.—Except as provided in
22 paragraph (2), in the case of a utilization re-
23 view activity involving the prior authorization of
24 health care items and services for an individual,
25 the utilization review program shall make a de-

1 termination concerning such authorization, and
2 provide notice of the determination to the indi-
3 vidual or the individual's designee and the indi-
4 vidual's health care provider by telephone and
5 in printed form, as soon as possible in accord-
6 ance with the medical exigencies of the case,
7 and in no event later than the deadline specified
8 in subparagraph (B)

9 (B) DEADLINE.—

10 (i) IN GENERAL.—Subject to clauses
11 (ii) and (iii), the deadline specified in this
12 subparagraph is 14 days after the date of
13 receipt of the request for prior authoriza-
14 tion, and all appropriate information shall
15 be provided at the time of the request.

16 (ii) EXTENSION PERMITTED WHERE
17 NOTICE OF ADDITIONAL INFORMATION RE-
18 QUIRED.—If a utilization review
19 program—

20 (I) receives a request for a prior
21 authorization,

22 (II) determines that additional
23 information is necessary to complete
24 the review and make the determina-
25 tion on the request,

1 (III) notifies the requester, not
2 later than 5 business days after the
3 date of receiving the request, of the
4 need for such specified additional in-
5 formation, and

6 (IV) requires the requester to
7 submit specified information not later
8 than 2 business days after notifica-
9 tion,

10 the deadline specified in this subparagraph
11 is 14 days after the date the program re-
12 ceives the specified additional information,
13 but in no case later than 28 days after the
14 date of receipt of the request for the prior
15 authorization. This clause shall not apply
16 if the deadline is specified in clause (iii).

17 (iii) EXPEDITED CASES.—In the case
18 of a situation described in section
19 102(c)(1)(A), the deadline specified in this
20 subparagraph is 48 hours after the time of
21 the request for prior authorization.

22 (2) ONGOING CARE.—

23 (A) CONCURRENT REVIEW.—

24 (i) IN GENERAL.—Subject to subpara-
25 graph (B), in the case of a concurrent re-

1 view of ongoing care (including hospitaliza-
2 tion), which results in a termination or re-
3 duction of such care, the plan must provide
4 by telephone and in printed form notice of
5 the concurrent review determination to the
6 individual or the individual's designee and
7 the individual's health care provider as
8 soon as possible in accordance with the
9 medical exigencies of the case, with suffi-
10 cient time prior to the termination or re-
11 duction to allow for an appeal under sec-
12 tion 102(c)(1)(A) to be completed before
13 the termination or reduction takes effect.

14 (ii) CONTENTS OF NOTICE.—Such no-
15 tice shall include, with respect to ongoing
16 health care items and services, the number
17 of ongoing services approved, the new total
18 of approved services, the date of onset of
19 services, and the next review date, if any,
20 as well as a statement of the individual's
21 rights to further appeal.

22 (B) EXCEPTION.—Subparagraph (A) shall
23 not be interpreted as requiring plans or issuers
24 to provide coverage of care that would exceed
25 the coverage limitations for such care.

1 (3) PREVIOUSLY PROVIDED SERVICES.—In the
2 case of a utilization review activity involving retro-
3 spective review of health care services previously pro-
4 vided for an individual, the utilization review pro-
5 gram shall make a determination concerning such
6 services, and provide notice of the determination to
7 the individual or the individual’s designee and the
8 individual’s health care provider by telephone and in
9 printed form, within 30 days of the date of receipt
10 of information that is reasonably necessary to make
11 such determination, but in no case later than 60
12 days after the date of receipt of the claim for bene-
13 fits.

14 (4) FAILURE TO MEET DEADLINE.—In a case
15 in which a group health plan or health insurance
16 issuer fails to make a determination on a claim for
17 benefit under paragraph (1), (2)(A), or (3) by the
18 applicable deadline established under the respective
19 paragraph, the failure shall be treated under this
20 subtitle as a denial of the claim as of the date of the
21 deadline.

22 (5) REFERENCE TO SPECIAL RULES FOR EMER-
23 GENCY SERVICES, MAINTENANCE CARE, POST-STA-
24 BILIZATION CARE, AND EMERGENCY AMBULANCE
25 SERVICES.—For waiver of prior authorization re-

1 requirements in certain cases involving emergency
2 services, maintenance care and post-stabilization
3 care, and emergency ambulance services, see sub-
4 sections (a)(1), (b), and (c)(1) of section 113, re-
5 spectively.

6 (e) NOTICE OF DENIALS OF CLAIMS FOR BENE-
7 FITS.—

8 (1) IN GENERAL.—Notice of a denial of claims
9 for benefits under a utilization review program shall
10 be provided in printed form and written in a manner
11 calculated to be understood by the participant, bene-
12 ficiary, or enrollee and shall include—

13 (A) the reasons for the denial (including
14 the clinical rationale);

15 (B) instructions on how to initiate an ap-
16 peal under section 102; and

17 (C) notice of the availability, upon request
18 of the individual (or the individual's designee)
19 of the clinical review criteria relied upon to
20 make such denial.

21 (2) SPECIFICATION OF ANY ADDITIONAL INFOR-
22 MATION.—Such a notice shall also specify what (if
23 any) additional necessary information must be pro-
24 vided to, or obtained by, the person making the de-
25 nial in order to make a decision on such an appeal.

1 (f) CLAIM FOR BENEFITS AND DENIAL OF CLAIM
 2 FOR BENEFITS DEFINED.—For purposes of this subtitle:

3 (1) CLAIM FOR BENEFITS.—The term “claim
 4 for benefits” means any request for coverage (in-
 5 cluding authorization of coverage), for eligibility, or
 6 for payment in whole or in part, for an item or serv-
 7 ice under a group health plan or health insurance
 8 coverage.

9 (2) DENIAL OF CLAIM FOR BENEFITS.—The
 10 term “denial” means, with respect to a claim for
 11 benefits, means a denial, or a failure to act on a
 12 timely basis upon, in whole or in part, the claim for
 13 benefits and includes a failure to provide benefits
 14 (including items and services) required to be pro-
 15 vided under this title.

16 **SEC. 102. INTERNAL APPEALS PROCEDURES.**

17 (a) RIGHT OF REVIEW.—

18 (1) IN GENERAL.—Each group health plan, and
 19 each health insurance issuer offering health insur-
 20 ance coverage—

21 (A) shall provide adequate notice in writ-
 22 ing to any participant or beneficiary under such
 23 plan, or enrollee under such coverage, whose
 24 claim for benefits under the plan or coverage
 25 has been denied (within the meaning of section

101(f)(2)), setting forth the specific reasons for such denial of claim for benefits and rights to any further review or appeal, written in layman's terms to be understood by the participant, beneficiary, or enrollee; and

(B) shall afford such a participant, beneficiary, or enrollee (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if the individual is medically unable to provide such consent) who is dissatisfied with such a denial of claim for benefits a reasonable opportunity of not less than 180 days to request and obtain a full and fair review by a named fiduciary (with respect to such plan) or named appropriate individual (with respect to such coverage) of the decision denying the claim.

(2) TREATMENT OF ORAL REQUESTS.—The request for review under paragraph (1)(B) may be made orally, but, in the case of an oral request, shall be followed by a request in writing.

(b) INTERNAL REVIEW PROCESS.—

(1) CONDUCT OF REVIEW.—

1 (A) IN GENERAL.—A review of a denial of
2 claim under this section shall be made by an in-
3 dividual (who shall be a physician in a case in-
4 volving medical judgment) who has been se-
5 lected by the plan or issuer and who did not
6 make the initial denial in the internally appeal-
7 able decision, except that in the case of limited
8 scope coverage (as defined in subparagraph
9 (B)) an appropriate specialist shall review the
10 decision.

11 (B) LIMITED SCOPE COVERAGE DE-
12 FINED.—For purposes of subparagraph (A), the
13 term “limited scope coverage” means a group
14 health plan or health insurance coverage the
15 only benefits under which are for benefits de-
16 scribed in section 2791(c)(2)(A) of the Public
17 Health Service Act (42 U.S.C. 300gg–91(c)(2)).

18 (2) TIME LIMITS FOR INTERNAL REVIEWS.—

19 (A) IN GENERAL.—Having received such a
20 request for review of a denial of claim, the plan
21 or issuer shall, in accordance with the medical
22 exigencies of the case but not later than the
23 deadline specified in subparagraph (B), com-
24 plete the review on the denial and transmit to
25 the participant, beneficiary, enrollee, or other

1 person involved a decision that affirms, re-
2 verses, or modifies the denial. If the decision
3 does not reverse the denial, the plan or issuer
4 shall transmit, in printed form, a notice that
5 sets forth the grounds for such decision and
6 that includes a description of rights to any fur-
7 ther appeal. Such decision shall be treated as
8 the final decision of the plan. Failure to issue
9 such a decision by such deadline shall be treat-
10 ed as a final decision affirming the denial of
11 claim.

12 (B) DEADLINE.—

13 (i) IN GENERAL.—Subject to clauses
14 (ii) and (iii), the deadline specified in this
15 subparagraph is 14 days after the date of
16 receipt of the request for internal review,
17 and all information shall be provided at the
18 time of the request.

19 (ii) EXTENSION PERMITTED WHERE
20 NOTICE OF ADDITIONAL INFORMATION RE-
21 QUIRED.—If a group health plan or health
22 insurance issuer—

23 (I) receives a request for internal
24 review,

1 (II) determines that additional
2 information is necessary to complete
3 the review and make the determina-
4 tion on the request,

5 (III) notifies the requester, not
6 later than 5 business days after the
7 date of receiving the request, of the
8 need for such specified additional in-
9 formation, and

10 (IV) requires the requester to
11 submit specified information not later
12 than 48 hours after notification,

13 the deadline specified in this subparagraph
14 is 14 days after the date the plan or issuer
15 receives the specified additional informa-
16 tion, but in no case later than 28 days
17 after the date of receipt of the request for
18 the internal review. This clause shall not
19 apply if the deadline is specified in clause
20 (iii).

21 (iii) EXPEDITED CASES.—In the case
22 of a situation described in subsection
23 (c)(1)(A), the deadline specified in this
24 subparagraph is 48 hours after the time of
25 the request for review.

1 (c) EXPEDITED REVIEW PROCESS.—

2 (1) IN GENERAL.—A group health plan, and a
3 health insurance issuer, shall establish procedures in
4 writing for the expedited consideration of requests
5 for review under subsection (b) in situations—

6 (A) in which, as determined by the plan or
7 issuer or as certified in writing by a treating
8 physician, the application of the normal time-
9 frame for making a determination could seri-
10 ously jeopardize the life or health of the partici-
11 pant, beneficiary, or enrollee or such an individ-
12 ual's ability to regain maximum function; or

13 (B) described in section 101(d)(2) (relat-
14 ing to requests for continuation of ongoing care
15 which would otherwise be reduced or termi-
16 nated).

17 (2) PROCESS.—Under such procedures—

18 (A) the request for expedited review may
19 be submitted orally or in writing by an indi-
20 vidual or provider who is otherwise entitled to
21 request the review;

22 (B) all necessary information, including
23 the plan's or issuer's decision, shall be trans-
24 mitted between the plan or issuer and the re-

1 quester by telephone, facsimile, or other simi-
2 larly expeditious available method; and

3 (C) the plan or issuer shall expedite the re-
4 view in the case of any of the situations de-
5 scribed in subparagraph (A) or (B) of para-
6 graph (1).

7 (3) DEADLINE FOR DECISION.—The decision on
8 the expedited review must be made and commu-
9 nicated to the parties as soon as possible in accord-
10 ance with the medical exigencies of the case, and in
11 no event later than 48 hours after the time of re-
12 ceipt of the request for expedited review, except that
13 in a case described in paragraph (1)(B), the decision
14 must be made before the end of the approved period
15 of care.

16 (d) WAIVER OF PROCESS.—A plan or issuer may
17 waive its rights for an internal review under subsection
18 (b). In such case the participant, beneficiary, or enrollee
19 involved (and any designee or provider involved) shall be
20 relieved of any obligation to complete the review involved
21 and may, at the option of such participant, beneficiary,
22 enrollee, designee, or provider, proceed directly to seek
23 further appeal through any applicable external appeals
24 process.

1 **SEC. 103. EXTERNAL APPEALS PROCEDURES.**

2 (a) RIGHT TO EXTERNAL APPEAL.—

3 (1) IN GENERAL.—A group health plan, and a
4 health insurance issuer offering health insurance
5 coverage, shall provide for an external appeals proc-
6 ess that meets the requirements of this section in
7 the case of an externally appealable decision de-
8 scribed in paragraph (2), for which a timely appeal
9 is made either by the plan or issuer or by the partic-
10 ipant, beneficiary, or enrollee (and any provider or
11 other person acting on behalf of such an individual
12 with the individual’s consent or without such consent
13 if such an individual is medically unable to provide
14 such consent).

15 (2) EXTERNALLY APPEALABLE DECISION DE-
16 FINED.—

17 (A) IN GENERAL.—For purposes of this
18 section, the term “externally appealable deci-
19 sion” means a denial of claim for benefits (as
20 defined in section 101(f)(2)), if—

21 (i) the item or service involved is a
22 covered benefit,

23 (ii) the amount involved exceeds \$100,
24 and

25 (iii) the requirements of subparagraph

26 (B) are met with respect to such denial.

1 Such term also includes a failure to meet an ap-
2 plicable deadline for internal review under sec-
3 tion 102 or such standards as are established
4 pursuant to section 118.

5 (B) REQUIREMENTS.—For purposes of
6 subparagraph (A)(iii), the requirements of this
7 subparagraph are met with respect to a denial
8 of a claim for benefits if—

9 (i) the denial is based in whole or in
10 part on a decision that the item or service
11 is not medically necessary or appropriate
12 or is investigational or experimental, or

13 (ii) in such denial, the decision as to
14 whether a benefit is covered involves a
15 medical judgment.

16 (C) EXCLUSIONS.—Such term does not
17 include—

18 (i) specific exclusions or express limi-
19 tations on the amount, duration, or scope
20 of coverage; or

21 (ii) a decision regarding eligibility for
22 any benefits.

23 (3) EXHAUSTION OF INTERNAL REVIEW PROC-
24 ESS.—Except as provided under section 102(d), a
25 plan or issuer may condition the use of an external

1 appeal process in the case of an externally appeal-
2 able decision upon a final decision in an internal re-
3 view under section 102, but only if the decision is
4 made in a timely basis consistent with the deadlines
5 provided under this subtitle.

6 (4) FILING FEE REQUIREMENT.—

7 (A) IN GENERAL.—A plan or issuer may
8 condition the use of an external appeal process
9 upon payment in advance to the plan or issuer
10 of a \$25 filing fee.

11 (B) REFUNDING FEE IN CASE OF SUC-
12 CESSFUL APPEALS.—The plan or issuer shall
13 refund payment of the filing fee under this
14 paragraph if the recommendation of the exter-
15 nal appeal entity is to reverse the denial of a
16 claim for benefits which is the subject of the
17 appeal.

18 (b) GENERAL ELEMENTS OF EXTERNAL APPEALS
19 PROCESS.—

20 (1) USE OF QUALIFIED EXTERNAL APPEAL EN-
21 TITY.—

22 (A) IN GENERAL.—Except as provided in
23 subparagraph (D), the external appeal process
24 under this section of a plan or issuer shall be
25 conducted between the plan or issuer and one

1 or more qualified external appeal entities (as
2 defined in subsection (c)).

3 (B) LIMITATION ON PLAN OR ISSUER SE-
4 LECTION.—The applicable authority shall im-
5 plement procedures—

6 (i) to assure that the selection process
7 among qualified external appeal entities
8 will not create any incentives for external
9 appeal entities to make a decision in a bi-
10 ased manner, and

11 (ii) for auditing a sample of decisions
12 by such entities to assure that no such de-
13 cisions are made in a biased manner.

14 (C) OTHER TERMS AND CONDITIONS.—
15 The terms and conditions of this paragraph
16 shall be consistent with the standards the ap-
17 propriate Secretary shall establish to assure
18 there is no real or apparent conflict of interest
19 in the conduct of external appeal activities. All
20 costs of the process (except those incurred by
21 the participant, beneficiary, enrollee, or treating
22 professional in support of the appeal) shall be
23 paid by the plan or issuer, and not by the par-
24 ticipant, beneficiary, or enrollee. The previous
25 sentence shall not be construed as applying to

1 the imposition of a filing fee under subsection
2 (a)(4).

3 (D) STATE AUTHORITY WITH RESPECT TO
4 QUALIFIED EXTERNAL APPEAL ENTITY FOR
5 HEALTH INSURANCE ISSUERS.—With respect to
6 health insurance issuers in a State, the State
7 may provide for external review activities to be
8 conducted by a qualified external appeal entity
9 that is designated by the State or that is se-
10 lected by the State in a manner determined by
11 the State to assure an unbiased determination.

12 (2) ELEMENTS OF PROCESS.—An external ap-
13 peal process shall be conducted consistent with
14 standards established by the appropriate Secretary
15 that include at least the following:

16 (A) FAIR AND DE NOVO DETERMINA-
17 TION.—The process shall provide for a fair, de
18 novo determination described in subparagraph
19 (B) based on evidence described in subpara-
20 graphs (C) and (D). However, nothing in this
21 paragraph shall be construed as providing for
22 coverage of items and services for which bene-
23 fits are not covered under the plan or coverage.

24 (B) STANDARD OF REVIEW.—An external
25 appeal entity shall determine whether the plan's

1 or issuer's decision is appropriate for the med-
2 ical condition of the patient involved (as deter-
3 mined by the entity) taking into account as of
4 the time of the entity's determination the pa-
5 tient's medical condition and any relevant and
6 reliable evidence the entity obtains under sub-
7 paragraphs (C) and (D). If the entity deter-
8 mines the decision is appropriate for such con-
9 dition, the entity shall affirm the decision and
10 to the extent that the entity determines the de-
11 cision is not appropriate for such condition, the
12 entity shall reverse the decision. Nothing in this
13 subparagraph shall be construed as providing
14 for coverage of items or services not provided
15 or covered by the plan.

16 (C) REQUIRED CONSIDERATION OF CER-
17 TAIN MATTERS.—In making such determina-
18 tion, the external appeal entity shall consider,
19 but not be bound by—

20 (i) any language in the plan or cov-
21 erage document relating to the definitions
22 of the terms medical necessity, medically
23 necessary or appropriate, or experimental,
24 investigational, or related terms;

1 (ii) the decision made by the plan or
2 issuer upon internal review under section
3 102 and any guidelines or standards used
4 by the plan or issuer in reaching such deci-
5 sion; and

6 (iii) the opinion of the individual's
7 treating physician or health care profes-
8 sional.

9 The entity also shall consider any personal
10 health and medical information supplied with
11 respect to the individual whose denial of claim
12 for benefits has been appealed.

13 (D) ADDITIONAL EVIDENCE.—Such entity
14 may also take into consideration but not be lim-
15 ited to the following evidence (to the extent
16 available):

17 (i) The results of studies that meet
18 professionally recognized standards of va-
19 lidity and replicability or that have been
20 published in peer-reviewed journals.

21 (ii) The results of professional con-
22 sensus conferences.

23 (iii) Practice and treatment policies.

1 (iv) Community standard of care and
2 generally accepted principles of profes-
3 sional medical practice.

4 (v) To the extent that the entity de-
5 termines it to be free of any conflict of in-
6 terest, the opinions of individuals who are
7 qualified as experts in one or more fields
8 of health care which are directly related to
9 the matters under appeal.

10 (vi) To the extent that the entity de-
11 termines it to be free of any conflict of in-
12 terest, the results of peer reviews con-
13 ducted by the plan or issuer involved.

14 (E) DETERMINATION CONCERNING EXTER-
15 NALLY APPEALABLE DECISIONS.—A qualified
16 external appeal entity shall determine—

17 (i) whether a denial of claim for bene-
18 fits is an externally appealable decision
19 (within the meaning of subsection (a)(2));

20 (ii) whether an externally appealable
21 decision involves an expedited appeal;

22 (iii) for purposes of initiating an ex-
23 ternal review, whether the internal review
24 process has been completed; and

1 (iv) whether the denial of claims is a
2 covered benefit.

3 (F) OPPORTUNITY TO SUBMIT EVI-
4 DENCE.—Each party to an externally appeal-
5 able decision may submit evidence related to the
6 issues in dispute.

7 (G) PROVISION OF INFORMATION.—The
8 plan or issuer involved shall provide timely ac-
9 cess to the external appeal entity to information
10 and to provisions of the plan or health insur-
11 ance coverage relating to the matter of the ex-
12 ternally appealable decision, as determined by
13 the entity.

14 (H) TIMELY DECISIONS.—A determination
15 by the external appeal entity on the decision
16 shall—

17 (i) be made orally or in writing and,
18 if it is made orally, shall be supplied to the
19 parties in writing as soon as possible;

20 (ii) be made in accordance with the
21 medical exigencies of the case involved, but
22 in no event later than 21 days after the
23 date (or, in the case of an expedited ap-
24 peal, 48 hours after the time) of requesting
25 an external appeal of the decision;

1 (iii) state, in layperson’s language, the
2 basis for the determination, including, if
3 relevant, any basis in the terms or condi-
4 tions of the plan or coverage; and

5 (iv) inform the participant, bene-
6 ficiary, or enrollee of the individual’s rights
7 (including any limitation on such rights) to
8 seek binding arbitration or further review
9 by the courts (or other process) of the ex-
10 ternal appeal determination.

11 (I) COMPLIANCE WITH DETERMINATION.—

12 If the external appeal entity determines that a
13 denial of a claim for benefits was not reason-
14 able and reverses the denial, the plan or
15 issuer—

16 (i) shall (upon the receipt of the de-
17 termination) authorize benefits in accord-
18 ance with such determination;

19 (ii) shall take such actions as may be
20 necessary to provide benefits (including
21 items or services) in a timely manner con-
22 sistent with such determination; and

23 (iii) shall submit information to the
24 entity documenting compliance with the

1 entity’s determination and this subpara-
2 graph.

3 (c) QUALIFICATIONS OF EXTERNAL APPEAL ENTI-
4 TIES.—

5 (1) IN GENERAL.—For purposes of this section,
6 the term “qualified external appeal entity” means,
7 in relation to a plan or issuer, an entity that is cer-
8 tified under paragraph (2) as meeting the following
9 requirements:

10 (A) The entity meets the independence re-
11 quirements of paragraph (3).

12 (B) The entity conducts external appeal
13 activities through at least three clinical peers
14 who are practicing physicians.

15 (C) The entity has sufficient medical, legal,
16 and other expertise and sufficient staffing to
17 conduct external appeal activities for the plan
18 or issuer on a timely basis consistent with sub-
19 section (b)(2)(G).

20 (2) INITIAL CERTIFICATION OF EXTERNAL AP-
21 PEAL ENTITIES.—

22 (A) IN GENERAL.—In order to be treated
23 as a qualified external appeal entity with re-
24 spect to—

1 (i) a group health plan, the entity
2 must be certified (and, in accordance with
3 subparagraph (B), periodically recertified)
4 as meeting the requirements of paragraph
5 (1)—

6 (I) by the Secretary of Labor;

7 (II) under a process recognized
8 or approved by the Secretary of
9 Labor; or

10 (III) to the extent provided in
11 subparagraph (C)(i), by a qualified
12 private standard-setting organization
13 (certified under such subparagraph),
14 if elected by the entity; or

15 (ii) a health insurance issuer oper-
16 ating in a State, the entity must be cer-
17 tified (and, in accordance with subpara-
18 graph (B), periodically recertified) as
19 meeting such requirements—

20 (I) by the applicable State au-
21 thority (or under a process recognized
22 or approved by such authority); or

23 (II) if the State has not estab-
24 lished a certification and recertifi-
25 cation process for such entities, by the

1 Secretary of Health and Human Serv-
2 ices, under a process recognized or ap-
3 proved by such Secretary, or to the
4 extent provided in subparagraph
5 (C)(ii), by a qualified private stand-
6 ard-setting organization (certified
7 under such subparagraph), if elected
8 by the entity.

9 (B) RECERTIFICATION PROCESS.—The ap-
10 propriate Secretary shall develop standards for
11 the recertification of external appeal entities.
12 Such standards shall include a review of—

- 13 (i) the number of cases reviewed;
- 14 (ii) a summary of the disposition of
15 those cases;
- 16 (iii) the length of time in making de-
17 terminations on those cases;
- 18 (iv) updated information of what was
19 required to be submitted as a condition of
20 certification for the entity's performance of
21 external appeal activities; and
- 22 (v) information necessary to assure
23 that the entity meets the independence re-
24 quirements (described in paragraph (3))

1 with respect to plans and issuers for which
2 it conducts external review activities.

3 (C) CERTIFICATION OF QUALIFIED PRI-
4 VATE STANDARD-SETTING ORGANIZATIONS.—

5 (i) FOR EXTERNAL REVIEWS UNDER
6 GROUP HEALTH PLANS.—For purposes of
7 subparagraph (A)(i)(III), the Secretary of
8 Labor may provide for a process for certifi-
9 cation (and periodic recertification) of
10 qualified private standard-setting organiza-
11 tions which provide for certification of ex-
12 ternal appeal entities. Such an organiza-
13 tion shall only be certified if the organiza-
14 tion does not certify an external appeal en-
15 tity unless it meets standards at least as
16 stringent as the standards required for cer-
17 tification of such an entity by such Sec-
18 retary under subparagraph (A)(i)(I).

19 (ii) FOR EXTERNAL REVIEWS OF
20 HEALTH INSURANCE ISSUERS.—For pur-
21 poses of subparagraph (A)(ii)(II), the Sec-
22 retary of Health and Human Services may
23 provide for a process for certification (and
24 periodic recertification) of qualified private
25 standard-setting organizations which pro-

1 vide for certification of external appeal en-
2 tities. Such an organization shall only be
3 certified if the organization does not certify
4 an external appeal entity unless it meets
5 standards as least as stringent as the
6 standards required for certification of such
7 an entity by such Secretary under subpara-
8 graph (A)(ii)(II).

9 (D) CONSTRUCTION.—Nothing in subpara-
10 graph (A)(i) shall be construed as permitting
11 the Secretary of Labor to delegate certification
12 authority under subclause (I) of such subpara-
13 graph to any person outside the Department of
14 Labor.

15 (3) INDEPENDENCE REQUIREMENTS.—

16 (A) IN GENERAL.—A clinical peer or other
17 entity meets the independence requirements of
18 this paragraph if—

19 (i) the peer or entity is not affiliated
20 with any related party;

21 (ii) any compensation received by such
22 peer or entity in connection with the exter-
23 nal review is reasonable and not contingent
24 on any decision rendered by the peer or en-
25 tity;

- 1 (iii) the plan and the issuer (if any)
2 have no recourse against the peer or entity
3 in connection with the external review; and
4 (iv) the peer or entity does not other-
5 wise have a conflict of interest with a re-
6 lated party.

7 (B) RELATED PARTY.—For purposes of
8 this paragraph, the term “related party”
9 means—

10 (i) with respect to—

11 (I) a group health plan or health
12 insurance coverage offered in connec-
13 tion with such a plan, the plan or the
14 health insurance issuer offering such
15 coverage, or

16 (II) individual health insurance
17 coverage, the health insurance issuer
18 offering such coverage,

19 or any plan sponsor, fiduciary, officer, di-
20 rector, or management employee of such
21 plan or issuer;

22 (ii) the health care professional that
23 provided the health care involved in the
24 coverage decision;

1 (iii) the institution at which the health
2 care involved in the coverage decision is
3 provided; or

4 (iv) the manufacturer of any drug or
5 other item that was included in the health
6 care involved in the coverage decision.

7 (C) AFFILIATED.—For purposes of this
8 paragraph, the term “affiliated” means, in con-
9 nection with any peer or entity, having a famil-
10 ial, financial, or fiduciary relationship with such
11 peer or entity.

12 (4) LIMITATION ON LIABILITY OF REVIEW-
13 ERS.—No qualified external appeal entity having a
14 contract with a plan or issuer under this part and
15 no person who is employed by any such entity or
16 who furnishes professional services to such entity,
17 shall be held by reason of the performance of any
18 duty, function, or activity required or authorized
19 pursuant to this section, to have violated any crimi-
20 nal law, or to be civilly liable under any law of the
21 United States or of any State (or political subdivi-
22 sion thereof) if due care was exercised in the per-
23 formance of such duty, function, or activity and
24 there was no actual malice or gross misconduct in
25 the performance of such duty, function, or activity.

1 (d) EXTERNAL APPEAL DETERMINATION BINDING
2 ON PLAN.—

3 (1) IN GENERAL.—The determination by an ex-
4 ternal appeal entity under this section shall be bind-
5 ing on the plan (and issuer, if any) involved in the
6 determination.

7 (2) PROTECTION OF LEGAL RIGHTS.—Nothing
8 in this subtitle shall be construed as removing any
9 legal rights of participants, beneficiaries, enrollees,
10 and others under State or Federal law, including the
11 right to file judicial actions to enforce rights.

12 (e) PENALTIES AGAINST AUTHORIZED OFFICIALS
13 FOR REFUSING TO AUTHORIZE THE DETERMINATION OF
14 AN EXTERNAL APPEAL ENTITY.—

15 (1) MONETARY PENALTIES.—In any case in
16 which the determination of an external appeal entity
17 is not followed in a timely fashion by a group health
18 plan, or by a health insurance issuer offering health
19 insurance coverage, any person who, acting in the
20 capacity of authorizing the benefit, causes such re-
21 fusals may, in the discretion in a court of competent
22 jurisdiction, be liable to an aggrieved participant,
23 beneficiary, or enrollee for a civil penalty in an
24 amount of up to \$1,000 a day from the date on
25 which the determination was transmitted to the plan

1 or issuer by the external appeal entity until the date
2 the refusal to provide the benefit is corrected.

3 (2) CEASE AND DESIST ORDER AND ORDER OF
4 ATTORNEY'S FEES.—In any action described in
5 paragraph (1) brought by a participant, beneficiary,
6 or enrollee with respect to a group health plan, or
7 a health insurance issuer offering health insurance
8 coverage, in which a plaintiff alleges that a person
9 referred to in such paragraph has taken an action
10 resulting in a refusal of a benefit determined by an
11 external appeal entity in violation of such terms of
12 the plan, coverage, or this subtitle, or has failed to
13 take an action for which such person is responsible
14 under the plan, coverage, or this title and which is
15 necessary under the plan or coverage for authorizing
16 a benefit, the court shall cause to be served on the
17 defendant an order requiring the defendant—

18 (A) to cease and desist from the alleged
19 action or failure to act; and

20 (B) to pay to the plaintiff a reasonable at-
21 torney's fee and other reasonable costs relating
22 to the prosecution of the action on the charges
23 on which the plaintiff prevails.

24 (f) PROTECTION OF LEGAL RIGHTS.—Nothing in
25 this subtitle shall be construed as removing or limiting any

1 legal rights of participants, beneficiaries, enrollees, and
2 others under State or Federal law (including section 502
3 of the Employee Retirement Income Security Act of
4 1974), including the right to file judicial actions to enforce
5 rights.

6 **SEC. 104. ESTABLISHMENT OF A GRIEVANCE PROCESS.**

7 (a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

8 (1) IN GENERAL.—A group health plan, and a
9 health insurance issuer in connection with the provi-
10 sion of health insurance coverage, shall establish and
11 maintain a system to provide for the presentation
12 and resolution of oral and written grievances
13 brought by individuals who are participants, bene-
14 ficiaries, or enrollees, or health care providers or
15 other individuals acting on behalf of an individual
16 and with the individual's consent or without such
17 consent if the individual is medically unable to pro-
18 vide such consent, regarding any aspect of the plan's
19 or issuer's services.

20 (2) GRIEVANCE DEFINED.—In this section, the
21 term “grievance” means any question, complaint, or
22 concern brought by a participant, beneficiary or en-
23 rollee that is not a claim for benefits.

1 (b) GRIEVANCE SYSTEM.—Such system shall include
 2 the following components with respect to individuals who
 3 are participants, beneficiaries, or enrollees:

4 (1) Written notification to all such individuals
 5 and providers of the telephone numbers and business
 6 addresses of the plan or issuer personnel responsible
 7 for resolution of grievances and appeals.

8 (2) A system to record and document, over a
 9 period of at least 3 previous years beginning two
 10 months after the date of the enactment of this Act,
 11 all grievances and appeals made and their status.

12 (3) A process providing processing and resolu-
 13 tion of grievances within 60 days.

14 (4) Procedures for follow-up action, including
 15 the methods to inform the person making the griev-
 16 ance of the resolution of the grievance.

17 Grievances are not subject to appeal under the previous
 18 provisions of this subtitle.

19 **Subtitle B—Access to Care**

20 **SEC. 111. CONSUMER CHOICE OPTION.**

21 (a) IN GENERAL.—If a health insurance issuer offers
 22 to enrollees health insurance coverage in connection with
 23 a group health plan which provides for coverage of services
 24 only if such services are furnished through health care
 25 professionals and providers who are members of a network

1 of health care professionals and providers who have en-
2 tered into a contract with the issuer to provide such serv-
3 ices, the issuer shall also offer to such enrollees (at the
4 time of enrollment and during an annual open season as
5 provided under subsection (c)) the option of health insur-
6 ance coverage which provides for coverage of such services
7 which are not furnished through health care professionals
8 and providers who are members of such a network unless
9 enrollees are offered such non-network coverage through
10 another health insurance issuer.

11 (b) ADDITIONAL COSTS.—The amount of any addi-
12 tional premium charged by the health insurance issuer for
13 the additional cost of the creation and maintenance of the
14 option described in subsection (a) and the amount of any
15 additional cost sharing imposed under such option shall
16 be borne by the enrollee unless it is paid by the health
17 plan sponsor through agreement with the health insurance
18 issuer.

19 (c) OPEN SEASON.—An enrollee may change to the
20 offering provided under this section only during a time pe-
21 riod determined by the health insurance issuer. Such time
22 period shall occur at least annually.

23 **SEC. 112. CHOICE OF HEALTH CARE PROFESSIONAL.**

24 (a) PRIMARY CARE.—If a group health plan, or a
25 health insurance issuer that offers health insurance cov-

1 erage, requires or provides for designation by a partici-
2 pant, beneficiary, or enrollee of a participating primary
3 care provider, then the plan or issuer shall permit each
4 participant, beneficiary, and enrollee to designate any par-
5 ticipating primary care provider who is available to accept
6 such individual.

7 (b) SPECIALISTS.—A group health plan and a health
8 insurance issuer that offers health insurance coverage
9 shall permit each participant, beneficiary, or enrollee to
10 receive medically necessary or appropriate specialty care,
11 pursuant to appropriate referral procedures, from any
12 qualified participating health care professional who is
13 available to accept such individual for such care.

14 **SEC. 113. ACCESS TO EMERGENCY CARE.**

15 (a) COVERAGE OF EMERGENCY SERVICES.—

16 (1) IN GENERAL.—If a group health plan, or
17 health insurance coverage offered by a health insur-
18 ance issuer, provides or covers any benefits with re-
19 spect to services in an emergency department of a
20 hospital, the plan or issuer shall cover emergency
21 services (as defined in paragraph (2)(B))—

22 (A) without the need for any prior author-
23 ization determination;

1 (B) whether or not the health care pro-
2 vider furnishing such services is a participating
3 provider with respect to such services;

4 (C) in a manner so that, if such services
5 are provided to a participant, beneficiary, or
6 enrollee—

7 (i) by a nonparticipating health care
8 provider with or without prior authoriza-
9 tion, or

10 (ii) by a participating health care pro-
11 vider without prior authorization,
12 the participant, beneficiary, or enrollee is not
13 liable for amounts that exceed the amounts of
14 liability that would be incurred if the services
15 were provided by a participating health care
16 provider with prior authorization; and

17 (D) without regard to any other term or
18 condition of such coverage (other than exclusion
19 or coordination of benefits, or an affiliation or
20 waiting period, permitted under section 2701 of
21 the Public Health Service Act, section 701 of
22 the Employee Retirement Income Security Act
23 of 1974, or section 9801 of the Internal Rev-
24 enue Code of 1986, and other than applicable
25 cost-sharing).

1 (2) DEFINITIONS.—In this section:

2 (A) EMERGENCY MEDICAL CONDITION.—

3 The term “emergency medical condition”
4 means—

5 (i) a medical condition manifesting
6 itself by acute symptoms of sufficient se-
7 verity (including severe pain) such that a
8 prudent layperson, who possesses an aver-
9 age knowledge of health and medicine,
10 could reasonably expect the absence of im-
11 mediate medical attention to result in a
12 condition described in clause (i), (ii), or
13 (iii) of section 1867(e)(1)(A) of the Social
14 Security Act; and

15 (ii) a medical condition manifesting
16 itself in a neonate by acute symptoms of
17 sufficient severity (including severe pain)
18 such that a prudent health care profes-
19 sional could reasonably expect the absence
20 of immediate medical attention to result in
21 a condition described in clause (i), (ii), or
22 (iii) of section 1867(e)(1)(A) of the Social
23 Security Act.

24 (B) EMERGENCY SERVICES.—The term
25 “emergency services” means—

1 (i) with respect to an emergency med-
2 ical condition described in subparagraph
3 (A)(i)—

4 (I) a medical screening examina-
5 tion (as required under section 1867
6 of the Social Security Act) that is
7 within the capability of the emergency
8 department of a hospital, including
9 ancillary services routinely available to
10 the emergency department to evaluate
11 such emergency medical condition,
12 and

13 (II) within the capabilities of the
14 staff and facilities available at the
15 hospital, such further medical exam-
16 ination and treatment as are required
17 under section 1867 of such Act to sta-
18 bilize the patient; or

19 (ii) with respect to an emergency med-
20 ical condition described in subparagraph
21 (A)(ii), medical treatment for such condi-
22 tion rendered by a health care provider in
23 a hospital to a neonate, including available
24 hospital ancillary services in response to an
25 urgent request of a health care profes-

1 sional and to the extent necessary to sta-
2 bilize the neonate.

3 (C) STABILIZE.—The term “to stabilize”
4 means, with respect to an emergency medical
5 condition, to provide such medical treatment of
6 the condition as may be necessary to assure,
7 within reasonable medical probability, that no
8 material deterioration of the condition is likely
9 to result from or occur during the transfer of
10 the individual from a facility.

11 (b) REIMBURSEMENT FOR MAINTENANCE CARE AND
12 POST-STABILIZATION CARE.—If benefits are available
13 under a group health plan, or under health insurance cov-
14 erage offered by a health insurance issuer, with respect
15 to maintenance care or post-stabilization care covered
16 under the guidelines established under section 1852(d)(2)
17 of the Social Security Act, the plan or issuer shall provide
18 for reimbursement with respect to such services provided
19 to a participant, beneficiary, or enrollee other than
20 through a participating health care provider in a manner
21 consistent with subsection (a)(1)(C) (and shall otherwise
22 comply with such guidelines).

23 (c) COVERAGE OF EMERGENCY AMBULANCE SERV-
24 ICES.—

1 (1) IN GENERAL.—If a group health plan, or
2 health insurance coverage provided by a health in-
3 surance issuer, provides any benefits with respect to
4 ambulance services and emergency services, the plan
5 or issuer shall cover emergency ambulance services
6 (as defined in paragraph (2))) furnished under the
7 plan or coverage under the same terms and condi-
8 tions under subparagraphs (A) through (D) of sub-
9 section (a)(1) under which coverage is provided for
10 emergency services.

11 (2) EMERGENCY AMBULANCE SERVICES.—For
12 purposes of this subsection, the term “emergency
13 ambulance services” means ambulance services (as
14 defined for purposes of section 1861(s)(7) of the So-
15 cial Security Act) furnished to transport an indi-
16 vidual who has an emergency medical condition (as
17 defined in subsection (a)(2)(A)) to a hospital for the
18 receipt of emergency services (as defined in sub-
19 section (a)(2)(B)) in a case in which the emergency
20 services are covered under the plan or coverage pur-
21 suant to subsection (a)(1) and a prudent layperson,
22 with an average knowledge of health and medicine,
23 could reasonably expect that the absence of such
24 transport would result in placing the health of the
25 individual in serious jeopardy, serious impairment of

1 bodily function, or serious dysfunction of any bodily
2 organ or part.

3 **SEC. 114. ACCESS TO SPECIALTY CARE.**

4 (a) SPECIALTY CARE FOR COVERED SERVICES.—

5 (1) IN GENERAL.—If—

6 (A) an individual is a participant or bene-
7 ficiary under a group health plan or an enrollee
8 who is covered under health insurance coverage
9 offered by a health insurance issuer,

10 (B) the individual has a condition or dis-
11 ease of sufficient seriousness and complexity to
12 require treatment by a specialist or the indi-
13 vidual requires physician pathology services,
14 and

15 (C) benefits for such treatment or services
16 are provided under the plan or coverage,
17 the plan or issuer shall make or provide for a refer-
18 ral to a specialist who is available and accessible
19 (consistent with standards developed under section
20 118) to provide the treatment for such condition or
21 disease or to provide such services.

22 (2) SPECIALIST DEFINED.—For purposes of
23 this subsection, the term “specialist” means, with
24 respect to a condition or services, a health care prac-
25 titioner, facility, or center or physician pathologist

1 that has adequate expertise through appropriate
2 training and experience (including, in the case of a
3 child, appropriate pediatric expertise and in the case
4 of a pregnant woman, appropriate obstetrical exper-
5 tise) to provide high quality care in treating the con-
6 dition or to provide physician pathology services.

7 (3) CARE UNDER REFERRAL.—A group health
8 plan or health insurance issuer may require that the
9 care provided to an individual pursuant to such re-
10 ferral under paragraph (1) with respect to treatment
11 be—

12 (A) pursuant to a treatment plan, only if
13 the treatment plan is developed by the specialist
14 and approved by the plan or issuer, in consulta-
15 tion with the designated primary care provider
16 or specialist and the individual (or the individ-
17 ual's designee), and

18 (B) in accordance with applicable quality
19 assurance and utilization review standards of
20 the plan or issuer.

21 Nothing in this subsection shall be construed as pre-
22 venting such a treatment plan for an individual from
23 requiring a specialist to provide the primary care
24 provider with regular updates on the specialty care

1 provided, as well as all necessary medical informa-
2 tion.

3 (4) REFERRALS TO PARTICIPATING PRO-
4 VIDERS.—A group health plan or health insurance
5 issuer is not required under paragraph (1) to pro-
6 vide for a referral to a specialist that is not a par-
7 ticipating provider, unless the plan or issuer does
8 not have a specialist that is available and accessible
9 to treat the individual's condition or provide physi-
10 cian pathology services and that is a participating
11 provider with respect to such treatment or services.

12 (5) REFERRALS TO NONPARTICIPATING PRO-
13 VIDERS.—In a case in which a referral of an indi-
14 vidual to a nonparticipating specialist is required
15 under paragraph (1), the group health plan or
16 health insurance issuer shall provide the individual
17 the option of at least three nonparticipating special-
18 ists.

19 (6) TREATMENT OF NONPARTICIPATING PRO-
20 VIDERS.—If a plan or issuer refers an individual to
21 a nonparticipating specialist pursuant to paragraph
22 (1), services provided pursuant to the approved
23 treatment plan (if any) shall be provided at no addi-
24 tional cost to the individual beyond what the indi-

1 vidual would otherwise pay for services received by
2 such a specialist that is a participating provider.

3 (b) SPECIALISTS AS GATEKEEPER FOR TREATMENT
4 OF ONGOING SPECIAL CONDITIONS.—

5 (1) IN GENERAL.—A group health plan, or a
6 health insurance issuer, in connection with the provi-
7 sion of health insurance coverage, shall have a proce-
8 dure by which an individual who is a participant,
9 beneficiary, or enrollee and who has an ongoing spe-
10 cial condition (as defined in paragraph (3)) may re-
11 quest and receive a referral to a specialist for such
12 condition who shall be responsible for and capable of
13 providing and coordinating the individual's care with
14 respect to the condition. Under such procedures if
15 such an individual's care would most appropriately
16 be coordinated by such a specialist, such plan or
17 issuer shall refer the individual to such specialist.

18 (2) TREATMENT FOR RELATED REFERRALS.—
19 Such specialists shall be permitted to treat the indi-
20 vidual without a referral from the individual's pri-
21 mary care provider and may authorize such refer-
22 rals, procedures, tests, and other medical services as
23 the individual's primary care provider would other-
24 wise be permitted to provide or authorize, subject to
25 the terms of the treatment (referred to in subsection

1 (a)(3)(A)) with respect to the ongoing special condi-
2 tion.

3 (3) ONGOING SPECIAL CONDITION DEFINED.—

4 In this subsection, the term “ongoing special condi-
5 tion” means a condition or disease that—

6 (A) is life-threatening, degenerative, or dis-
7 abling, and

8 (B) requires specialized medical care over
9 a prolonged period of time.

10 (4) TERMS OF REFERRAL.—The provisions of
11 paragraphs (3) through (5) of subsection (a) apply
12 with respect to referrals under paragraph (1) of this
13 subsection in the same manner as they apply to re-
14 ferrals under subsection (a)(1).

15 (5) CONSTRUCTION.—Nothing in this sub-
16 section shall be construed as preventing an indi-
17 vidual who is a participant, beneficiary, or enrollee
18 and who has an ongoing special condition from hav-
19 ing the individual’s primary care physician assume
20 the responsibilities for providing and coordinating
21 care described in paragraph (1).

22 (c) STANDING REFERRALS.—

23 (1) IN GENERAL.—A group health plan, and a
24 health insurance issuer in connection with the provi-
25 sion of health insurance coverage, shall have a proce-

1 dure by which an individual who is a participant,
 2 beneficiary, or enrollee and who has a condition that
 3 requires ongoing care from a specialist may receive
 4 a standing referral to such specialist for treatment
 5 of such condition. If the plan or issuer, or if the pri-
 6 mary care provider in consultation with the medical
 7 director of the plan or issuer and the specialist (if
 8 any), determines that such a standing referral is ap-
 9 propriate, the plan or issuer shall make such a refer-
 10 ral to such a specialist if the individual so desires.

11 (2) TERMS OF REFERRAL.—The provisions of
 12 paragraphs (3) through (5) of subsection (a) apply
 13 with respect to referrals under paragraph (1) of this
 14 subsection in the same manner as they apply to re-
 15 ferrals under subsection (a)(1).

16 **SEC. 115. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL**
 17 **CARE.**

18 (a) IN GENERAL.—If a group health plan, or a health
 19 insurance issuer in connection with the provision of health
 20 insurance coverage, requires or provides for a participant,
 21 beneficiary, or enrollee to designate a participating pri-
 22 mary care health care professional, the plan or issuer—
 23 (1) may not require authorization or a referral
 24 by the individual's primary care health care profes-
 25 sional or otherwise for coverage of routine gynecolo-

1 logical care (including preventive women’s health ex-
2 aminations) and pregnancy-related services provided
3 by a participating physician (including a family
4 practice physician) who specializes or is trained and
5 experienced in obstetrics and gynecology to the ex-
6 tent such care is otherwise covered, and

7 (2) shall treat the ordering of other obstetrical
8 or gynecological care by such a participating physi-
9 cian as the authorization of the primary care health
10 care professional with respect to such care under the
11 plan or coverage.

12 (b) CONSTRUCTION.—Nothing in subsection (a) shall
13 be construed to—

14 (1) waive any exclusions of coverage under the
15 terms of the plan with respect to coverage of obstet-
16 rical or gynecological care; or

17 (2) preclude the group health plan or health in-
18 surance issuer involved from requiring that the ob-
19 stetrician or gynecologist notify the primary care
20 health care professional or the plan of treatment de-
21 cisions.

22 **SEC. 116. ACCESS TO PEDIATRIC CARE.**

23 (a) PEDIATRIC CARE.—If a group health plan, or a
24 health insurance issuer in connection with the provision
25 of health insurance coverage, requires or provides for an

1 enrollee to designate a participating primary care provider
2 for a child of such enrollee, the plan or issuer shall permit
3 the enrollee to designate a physician (including a family
4 practice physician) who specializes or is trained and expe-
5 rienced in pediatrics as the child's primary care provider.

6 (b) CONSTRUCTION.—Nothing in subsection (a) shall
7 be construed to waive any exclusions of coverage under
8 the terms of the plan with respect to coverage of pediatric
9 care.

10 **SEC. 117. CONTINUITY OF CARE.**

11 (a) IN GENERAL.—

12 (1) TERMINATION OF PROVIDER.—If a contract
13 between a group health plan, or a health insurance
14 issuer in connection with the provision of health in-
15 surance coverage, and a health care provider is ter-
16 minated (as defined in paragraph (3)(B)), or bene-
17 fits or coverage provided by a health care provider
18 are terminated because of a change in the terms of
19 provider participation in a group health plan, and
20 an individual who is a participant, beneficiary, or en-
21 rollee in the plan or coverage is undergoing treat-
22 ment from the provider for an ongoing special condi-
23 tion (as defined in paragraph (3)(A)) at the time
24 of such termination, the plan or issuer shall—

1 (A) notify the individual on a timely basis
2 of such termination and of the right to elect
3 continuation of coverage of treatment by the
4 provider under this section; and

5 (B) subject to subsection (c), permit the
6 individual to elect to continue to be covered
7 with respect treatment by the provider of such
8 condition during a transitional period (provided
9 under subsection (b)).

10 (2) TREATMENT OF TERMINATION OF CON-
11 TRACT WITH HEALTH INSURANCE ISSUER.—If a
12 contract for the provision of health insurance cov-
13 erage between a group health plan and a health in-
14 surance issuer is terminated and, as a result of such
15 termination, coverage of services of a health care
16 provider is terminated with respect to an individual,
17 the provisions of paragraph (1) (and the succeeding
18 provisions of this section) shall apply under the plan
19 in the same manner as if there had been a contract
20 between the plan and the provider that had been ter-
21 minated, but only with respect to benefits that are
22 covered under the plan after the contract termi-
23 nation.

24 (3) DEFINITIONS.—For purposes of this sec-
25 tion:

1 (A) ONGOING SPECIAL CONDITION.—The
2 term “ongoing special condition” has the mean-
3 ing given such term in section 114(b)(3), and
4 also includes pregnancy.

5 (B) TERMINATION.—The term “termi-
6 nated” includes, with respect to a contract, the
7 expiration or nonrenewal of the contract, but
8 does not include a termination of the contract
9 by the plan or issuer for failure to meet applica-
10 ble quality standards or for fraud.

11 (b) TRANSITIONAL PERIOD.—

12 (1) IN GENERAL.—Except as provided in para-
13 graphs (2) through (4), the transitional period under
14 this subsection shall extend up to 90 days (as deter-
15 mined by the treating health care professional) after
16 the date of the notice described in subsection
17 (a)(1)(A) of the provider’s termination.

18 (2) SCHEDULED SURGERY AND ORGAN TRANS-
19 PLANTATION.—If surgery or organ transplantation
20 was scheduled for an individual before the date of
21 the announcement of the termination of the provider
22 status under subsection (a)(1)(A) or if the individual
23 on such date was on an established waiting list or
24 otherwise scheduled to have such surgery or trans-
25 plantation, the transitional period under this sub-

1 section with respect to the surgery or transplan-
2 tation shall extend beyond the period under para-
3 graph (1) and until the date of discharge of the indi-
4 vidual after completion of the surgery or transplan-
5 tation.

6 (3) PREGNANCY.—If—

7 (A) a participant, beneficiary, or enrollee
8 was determined to be pregnant at the time of
9 a provider's termination of participation, and

10 (B) the provider was treating the preg-
11 nancy before date of the termination,
12 the transitional period under this subsection with re-
13 spect to provider's treatment of the pregnancy shall
14 extend through the provision of post-partum care di-
15 rectly related to the delivery.

16 (4) TERMINAL ILLNESS.—If—

17 (A) a participant, beneficiary, or enrollee
18 was determined to be terminally ill (as deter-
19 mined under section 1861(dd)(3)(A) of the So-
20 cial Security Act) at the time of a provider's
21 termination of participation, and

22 (B) the provider was treating the terminal
23 illness before the date of termination,
24 the transitional period under this subsection shall
25 extend for the remainder of the individual's life for

1 care directly related to the treatment of the terminal
2 illness or its medical manifestations.

3 (c) PERMISSIBLE TERMS AND CONDITIONS.—A
4 group health plan or health insurance issuer may condi-
5 tion coverage of continued treatment by a provider under
6 subsection (a)(1)(B) upon the individual notifying the plan
7 of the election of continued coverage and upon the pro-
8 vider agreeing to the following terms and conditions:

9 (1) The provider agrees to accept reimburse-
10 ment from the plan or issuer and individual involved
11 (with respect to cost-sharing) at the rates applicable
12 prior to the start of the transitional period as pay-
13 ment in full (or, in the case described in subsection
14 (a)(2), at the rates applicable under the replacement
15 plan or issuer after the date of the termination of
16 the contract with the health insurance issuer) and
17 not to impose cost-sharing with respect to the indi-
18 vidual in an amount that would exceed the cost-shar-
19 ing that could have been imposed if the contract re-
20 ferred to in subsection (a)(1) had not been termi-
21 nated.

22 (2) The provider agrees to adhere to the quality
23 assurance standards of the plan or issuer responsible
24 for payment under paragraph (1) and to provide to

1 such plan or issuer necessary medical information
2 related to the care provided.

3 (3) The provider agrees otherwise to adhere to
4 such plan's or issuer's policies and procedures, in-
5 cluding procedures regarding referrals and obtaining
6 prior authorization and providing services pursuant
7 to a treatment plan (if any) approved by the plan or
8 issuer.

9 (d) CONSTRUCTION.—Nothing in this section shall be
10 construed to require the coverage of benefits which would
11 not have been covered if the provider involved remained
12 a participating provider.

13 **SEC. 118. NETWORK ADEQUACY.**

14 (a) REQUIREMENT.—A group health plan, and a
15 health insurance issuer providing health insurance cov-
16 erage, shall meet such standards for network adequacy as
17 are established by law pursuant to this section.

18 (b) DEVELOPMENT OF STANDARDS.—

19 (1) ESTABLISHMENT OF PANEL.—There is es-
20 tablished a panel to be known as the Health Care
21 Panel to Establish Network Adequacy Standards (in
22 this section referred to as the “Panel”).

23 (2) DUTIES OF PANEL.—The Panel shall devise
24 standards for group health plans and health insur-

1 ance issuers that offer health insurance coverage to
2 ensure that—

3 (A) participants, beneficiaries, and enroll-
4 ees have access to a sufficient number, mix, and
5 distribution of health care professionals and
6 providers; and

7 (B) covered items and services are avail-
8 able and accessible to each participant, bene-
9 ficiary, and enrollee—

10 (i) in the service area of the plan or
11 issuer;

12 (ii) at a variety of sites of service;

13 (iii) with reasonable promptness (in-
14 cluding reasonable hours of operation and
15 after hours services);

16 (iv) with reasonable proximity to the
17 residences or workplaces of enrollees; and

18 (v) in a manner that takes into ac-
19 count the diverse needs of enrollees and
20 reasonably assures continuity of care.

21 (c) MEMBERSHIP.—

22 (1) SIZE AND COMPOSITION.—The Panel shall
23 be composed of 15 members. The Secretary of
24 Health and Human Services, the Majority Leader of
25 the Senate, and the Speaker of House of Represent-

1 atives shall each appoint 1 member from representa-
2 tives of private insurance organizations, consumer
3 groups, State insurance commissioners, State med-
4 ical societies, and State medical specialty societies.

5 (2) TERMS OF APPOINTMENT.—The members
6 of the Panel shall serve for the life of the Panel.

7 (3) VACANCIES.—A vacancy in the Panel shall
8 not affect the power of the remaining members to
9 execute the duties of the Panel, but any such va-
10 cancy shall be filled in the same manner in which
11 the original appointment was made.

12 (d) PROCEDURES.—

13 (1) MEETINGS.—The Panel shall meet at the
14 call of a majority of its members.

15 (2) FIRST MEETING.—The Panel shall convene
16 not later than 60 days after the date of the enact-
17 ment of the Health Care Quality and Choice Act of
18 1999.

19 (3) QUORUM.—A quorum shall consist of a ma-
20 jority of the members of the Panel.

21 (4) HEARINGS.—For the purpose of carrying
22 out its duties, the Panel may hold such hearings and
23 undertake such other activities as the Panel deter-
24 mines to be necessary to carry out its duties.

25 (e) ADMINISTRATION.—

1 (1) COMPENSATION.—Except as provided in
2 paragraph (1), members of the Panel shall receive
3 no additional pay, allowances, or benefits by reason
4 of their service on the Panel.

5 (2) TRAVEL EXPENSES AND PER DIEM.—Each
6 member of the Panel who is not an officer or em-
7 ployee of the Federal Government shall receive travel
8 expenses and per diem in lieu of subsistence in ac-
9 cordance with sections 5702 and 5703 of title 5,
10 United States Code.

11 (3) CONTRACT AUTHORITY.—The Panel may
12 contract with and compensate government and pri-
13 vate agencies or persons for items and services,
14 without regard to section 3709 of the Revised Stat-
15 utes (41 U.S.C. 5).

16 (4) USE OF MAILS.—The Panel may use the
17 United States mails in the same manner and under
18 the same conditions as Federal agencies and shall,
19 for purposes of the frank, be considered a commis-
20 sion of Congress as described in section 3215 of title
21 39, United States Code.

22 (5) ADMINISTRATIVE SUPPORT SERVICES.—
23 Upon the request of the Panel, the Secretary of
24 Health and Human Services shall provide to the

1 Panel on a reimbursable basis such administrative
2 support services as the Panel may request.

3 (f) REPORT AND ESTABLISHMENT OF STANDARDS.—

4 Not later than 2 years after the first meeting, the Panel
5 shall submit a report to Congress and the Secretary of
6 Health and Human Services detailing the standards de-
7 vised under subsection (b) and recommendations regard-
8 ing the implementation of such standards. Such standards
9 shall take effect to the extent provided by Federal law en-
10 acted after the date of the submission of such report.

11 (g) TERMINATION.—The Panel shall terminate on
12 the day after submitting its report to the Secretary of
13 Health and Human Services under subsection (f).

14 **SEC. 119. ACCESS TO EXPERIMENTAL OR INVESTIGA-**
15 **TIONAL PRESCRIPTION DRUGS.**

16 No use of a prescription drug or medical device shall
17 be considered experimental or investigational under a
18 group health plan or under health insurance coverage pro-
19 vided by a health insurance issuer if such use is included
20 in the labeling authorized by the U.S. Food and Drug Ad-
21 ministration under section 505, 513 or 515 of the Federal
22 Food, Drug, and Cosmetic Act (21 U.S.C. 355) or under
23 section 351 of the Public Health Service Act (42 U.S.C.
24 262), unless such use is demonstrated to be unsafe or inef-
25 fective.

1 **Subtitle C—Access to Information**

2 **SEC. 121. PATIENT ACCESS TO INFORMATION.**

3 (a) DISCLOSURE REQUIREMENT.—

4 (1) GROUP HEALTH PLANS.—A group health
5 plan shall—

6 (A) provide to participants and bene-
7 ficiaries at the time of initial coverage under
8 the plan (or the effective date of this section, in
9 the case of individuals who are participants or
10 beneficiaries as of such date), and at least an-
11 nually thereafter, the information described in
12 subsection (b);

13 (B) provide to participants and bene-
14 ficiaries, within a reasonable period (as speci-
15 fied by the appropriate Secretary) before or
16 after the date of significant changes in the in-
17 formation described in subsection (b), informa-
18 tion on such significant changes; and

19 (C) upon request, make available to par-
20 ticipants and beneficiaries, the applicable au-
21 thority, and prospective participants and bene-
22 ficiaries, the information described in sub-
23 section (b) or (c).

24 The plan may charge a reasonable fee for provision
25 in printed form of any of the information described

1 in subsection (b) or (c) more than once during any
2 plan year.

3 (2) HEALTH INSURANCE ISSUERS.—A health
4 insurance issuer in connection with the provision of
5 health insurance coverage shall—

6 (A) provide to individuals enrolled under
7 such coverage at the time of enrollment, and at
8 least annually thereafter, the information de-
9 scribed in subsection (b) in printed form;

10 (B) provide to enrollees, within a reason-
11 able period (as specified by the appropriate Sec-
12 retary) before or after the date of significant
13 changes in the information described in sub-
14 section (b), information in printed form on such
15 significant changes; and

16 (C) upon request, make available to the
17 applicable authority, to individuals who are pro-
18 spective enrollees, and to the public the infor-
19 mation described in subsection (b) or (c) in
20 printed form.

21 (b) INFORMATION PROVIDED.—The information de-
22 scribed in this subsection with respect to a group health
23 plan or health insurance coverage offered by a health in-
24 surance issuer shall be provided to a participant, bene-

1 ficiary, or enrollee free of charge at least once a year and
2 includes the following:

3 (1) SERVICE AREA.—The service area of the
4 plan or issuer.

5 (2) BENEFITS.—Benefits offered under the
6 plan or coverage, including—

7 (A) those that are covered benefits (by ref-
8 erence to relevant CPT and DRG codes), limits
9 and conditions on such benefits, and those ben-
10 efits that are explicitly excluded from coverage
11 (by reference to relevant CPT and DRG codes);

12 (B) cost sharing, such as deductibles, coin-
13 surance, and copayment amounts, including any
14 liability for balance billing, any maximum limi-
15 tations on out of pocket expenses, and the max-
16 imum out of pocket costs for services that are
17 provided by nonparticipating providers or that
18 are furnished without meeting the applicable
19 utilization review requirements;

20 (C) the extent to which benefits may be ob-
21 tained from nonparticipating providers;

22 (D) the extent to which a participant, ben-
23 eficiary, or enrollee may select from among par-
24 ticipating providers and the types of providers
25 participating in the plan or issuer network;

1 (E) process for determining experimental
2 coverage; and

3 (F) use of a prescription drug formulary.

4 (3) ACCESS.—A description of the following:

5 (A) The number, mix, and distribution of
6 providers under the plan or coverage.

7 (B) Out-of-network coverage (if any) pro-
8 vided by the plan or coverage.

9 (C) Any point-of-service option (including
10 any supplemental premium or cost-sharing for
11 such option).

12 (D) The procedures for participants, bene-
13 ficiaries, and enrollees to select, access, and
14 change participating primary and specialty pro-
15 viders.

16 (E) The rights and procedures for obtain-
17 ing referrals (including standing referrals) to
18 participating and nonparticipating providers.

19 (F) The name, address, and telephone
20 number of participating health care providers
21 and an indication of whether each such provider
22 is available to accept new patients.

23 (G) Any limitations imposed on the selec-
24 tion of qualifying participating health care pro-

1 viders, including any limitations imposed under
2 section 112(b)(2).

3 (4) OUT-OF-AREA COVERAGE.—Out-of-area cov-
4 erage provided by the plan or issuer.

5 (5) EMERGENCY COVERAGE.—Coverage of
6 emergency services, including—

7 (A) the appropriate use of emergency serv-
8 ices, including use of the 911 telephone system
9 or its local equivalent in emergency situations
10 and an explanation of what constitutes an
11 emergency situation;

12 (B) the process and procedures of the plan
13 or issuer for obtaining emergency services; and

14 (C) the locations of (i) emergency depart-
15 ments, and (ii) other settings, in which plan
16 physicians and hospitals provide emergency
17 services and post-stabilization care.

18 (6) PRIOR AUTHORIZATION RULES.—Rules re-
19 garding prior authorization or other review require-
20 ments that could result in noncoverage or non-
21 payment.

22 (7) GRIEVANCE AND APPEALS PROCEDURES.—
23 All appeal or grievance rights and procedures under
24 the plan or coverage, including the method for filing
25 grievances and the time frames and circumstances

1 for acting on grievances and appeals, who is the ap-
2 plicable authority with respect to the plan or issuer.

3 (8) ACCOUNTABILITY.—A description of the
4 legal recourse options available for participants and
5 beneficiaries under the plan including—

6 (A) the preemption that applies under sec-
7 tion 514 of the Employee Retirement Income
8 Security Act of 1974 (29 U.S.C. 1144) to cer-
9 tain actions arising out of the provision of
10 health benefits; and

11 (B) the extent to which coverage decisions
12 made by the plan are subject to internal review
13 or any external review and the proper time
14 frames under.

15 (9) QUALITY ASSURANCE.—Any information
16 made public by an accrediting organization in the
17 process of accreditation of the plan or issuer or any
18 additional quality indicators the plan or issuer
19 makes available.

20 (10) INFORMATION ON ISSUER.—Notice of ap-
21 propriate mailing addresses and telephone numbers
22 to be used by participants, beneficiaries, and enroll-
23 ees in seeking information or authorization for treat-
24 ment.

1 (11) AVAILABILITY OF INFORMATION ON RE-
2 QUEST.—Notice that the information described in
3 subsection (c) is available upon request.

4 (c) INFORMATION MADE AVAILABLE UPON RE-
5 QUEST.—The information described in this subsection is
6 the following:

7 (1) UTILIZATION REVIEW ACTIVITIES.—A de-
8 scription of procedures used and requirements (in-
9 cluding circumstances, time frames, and appeal
10 rights) under any utilization review program under
11 section 101.

12 (2) GRIEVANCE AND APPEALS INFORMATION.—
13 Information on the number of grievances and ap-
14 peals and on the disposition in the aggregate of such
15 matters.

16 (3) FORMULARY RESTRICTIONS.—A description
17 of the nature of any drug formula restrictions.

18 (4) PARTICIPATING PROVIDER LIST.—A list of
19 current participating health care providers.

20 (d) CONSTRUCTION.—Nothing in this section shall be
21 construed as requiring public disclosure of individual con-
22 tracts or financial arrangements between a group health
23 plan or health insurance issuer and any provider.

1 **Subtitle D—Protecting the Doctor-**
2 **Patient Relationship**

3 **SEC. 131. PROHIBITION OF INTERFERENCE WITH CERTAIN**
4 **MEDICAL COMMUNICATIONS.**

5 (a) GENERAL RULE.—The provisions of any contract
6 or agreement, or the operation of any contract or agree-
7 ment, between a group health plan or health insurance
8 issuer in relation to health insurance coverage (including
9 any partnership, association, or other organization that
10 enters into or administers such a contract or agreement)
11 and a health care provider (or group of health care pro-
12 viders) shall not prohibit or otherwise restrict a health
13 care professional from advising such a participant, bene-
14 ficiary, or enrollee who is a patient of the professional
15 about the health status of the individual or medical care
16 or treatment for the individual's condition or disease, re-
17 gardless of whether benefits for such care or treatment
18 are provided under the plan or coverage, if the professional
19 is acting within the lawful scope of practice.

20 (b) NULLIFICATION.—Any contract provision or
21 agreement that restricts or prohibits medical communica-
22 tions in violation of subsection (a) shall be null and void.

23 (c) CONSTRUCTION.—Nothing in this title shall be
24 construed to require the sponsor of a group health plan,
25 or a health insurance issuer offering health insurance cov-

1 erage in connection with the group health plan, to provide,
2 reimburse for, or provide coverage of, a counseling or re-
3 ferral service if the plan or issuer objects to the provision
4 of such service on moral or religious grounds.

5 **SEC. 132. PROHIBITION OF DISCRIMINATION AGAINST PRO-**
6 **VIDERS BASED ON LICENSURE.**

7 (a) IN GENERAL.—A group health plan and a health
8 insurance issuer offering health insurance coverage shall
9 not discriminate with respect to participation or indem-
10 nification as to any provider who is acting within the scope
11 of the provider’s license or certification under applicable
12 State law, solely on the basis of such license or certifi-
13 cation.

14 (b) CONSTRUCTION.—Subsection (a) shall not be
15 construed—

16 (1) as requiring the coverage under a group
17 health plan or health insurance coverage of par-
18 ticular benefits or services or to prohibit a plan or
19 issuer from including providers only to the extent
20 necessary to meet the needs of the plan’s or issuer’s
21 participants, beneficiaries, or enrollees or from es-
22 tablishing any measure designed to maintain quality
23 and control costs consistent with the responsibilities
24 of the plan or issuer;

1 (2) to override any State licensure or scope-of-
2 practice law;

3 (3) as requiring a plan or issuer that offers net-
4 work coverage to include for participation every will-
5 ing provider who meets the terms and conditions of
6 the plan or issuer; or

7 (4) as prohibiting a family practice physician
8 with appropriate expertise from providing pediatric
9 or obstetrical or gynecological care.

10 **SEC. 133. PROHIBITION AGAINST IMPROPER INCENTIVE**
11 **ARRANGEMENTS.**

12 (a) IN GENERAL.—A group health plan and a health
13 insurance issuer offering health insurance coverage may
14 not operate any physician incentive plan (as defined in
15 subparagraph (B) of section 1876(i)(8) of the Social Secu-
16 rity Act) unless the requirements described in clauses (i),
17 (ii)(I), and (iii) of subparagraph (A) of such section are
18 met with respect to such a plan.

19 (b) APPLICATION.—For purposes of carrying out
20 paragraph (1), any reference in section 1876(i)(8) of the
21 Social Security Act to the Secretary, an eligible organiza-
22 tion, or an individual enrolled with the organization shall
23 be treated as a reference to the applicable authority, a
24 group health plan or health insurance issuer, respectively,

1 and a participant, beneficiary, or enrollee with the plan
 2 or organization, respectively.

3 (c) CONSTRUCTION.—Nothing in this section shall be
 4 construed as prohibiting all capitation and similar ar-
 5 rangements or all provider discount arrangements.

6 **SEC. 134. PAYMENT OF CLEAN CLAIMS.**

7 A group health plan, and a health insurance issuer
 8 offering group health insurance coverage, shall provide for
 9 prompt payment of claims submitted for health care serv-
 10 ices or supplies furnished to a participant, beneficiary, or
 11 enrollee with respect to benefits covered by the plan or
 12 issuer, in a manner consistent with the provisions of sec-
 13 tions 1816(c)(2) and 1842(c)(2) of the Social Security Act
 14 (42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), ex-
 15 cept that for purposes of this section, subparagraph (C)
 16 of section 1816(c)(2) of the Social Security Act shall be
 17 treated as applying to claims received from a participant,
 18 beneficiary, or enrollee as well as claims referred to in
 19 such subparagraph.

20 **Subtitle E—Definitions**

21 **SEC. 151. DEFINITIONS.**

22 (a) INCORPORATION OF GENERAL DEFINITIONS.—
 23 Except as otherwise provided, the provisions of section
 24 2971 of the Public Health Service Act shall apply for pur-

1 poses of this title in the same manner as they apply for
2 purposes of title XXVII of such Act.

3 (b) SECRETARY.—Except as otherwise provided, the
4 term “Secretary” means the Secretary of Health and
5 Human Services, in consultation with the Secretary of
6 Labor and the term “appropriate Secretary” means the
7 Secretary of Health and Human Services in relation to
8 carrying out this title under sections 2706 and 2751 of
9 the Public Health Service Act and the Secretary of Labor
10 in relation to carrying out this title under section 713 of
11 the Employee Retirement Income Security Act of 1974.

12 (c) ADDITIONAL DEFINITIONS.—For purposes of this
13 title:

14 (1) APPLICABLE AUTHORITY.—The term “ap-
15 plicable authority” means—

16 (A) in the case of a group health plan, the
17 Secretary of Health and Human Services and
18 the Secretary of Labor; and

19 (B) in the case of a health insurance issuer
20 with respect to a specific provision of this title,
21 the applicable State authority (as defined in
22 section 2791(d) of the Public Health Service
23 Act), or the Secretary of Health and Human
24 Services, if such Secretary is enforcing such

1 provision under section 2722(a)(2) or
2 2761(a)(2) of the Public Health Service Act.

3 (2) CLINICAL PEER.—The term “clinical peer”
4 means, with respect to a review or appeal, a prac-
5 ticing physician or other health care professional
6 who holds a nonrestricted license and who is—

7 (A) appropriately certified by a nationally
8 recognized, peer reviewed accrediting body in
9 the same or similar specialty as typically man-
10 ages the medical condition, procedure, or treat-
11 ment under review or appeal, or

12 (B) is trained and experienced in man-
13 aging such condition, procedure, or treatment,
14 and includes a pediatric specialist where appropriate;
15 except that only a physician may be a clinical peer
16 with respect to the review or appeal of treatment
17 recommended or rendered by a physician.

18 (3) ENROLLEE.—The term “enrollee” means,
19 with respect to health insurance coverage offered by
20 a health insurance issuer, an individual enrolled with
21 the issuer to receive such coverage.

22 (4) GROUP HEALTH PLAN.—The term “group
23 health plan” has the meaning given such term in
24 section 733(a) of the Employee Retirement Income
25 Security Act of 1974.

1 (5) HEALTH CARE PROFESSIONAL.—The term
2 “health care professional” means an individual who
3 is licensed, accredited, or certified under State law
4 to provide specified health care services and who is
5 operating within the scope of such licensure, accredi-
6 tation, or certification.

7 (6) HEALTH CARE PROVIDER.—The term
8 “health care provider” includes a physician or other
9 health care professional, as well as an institutional
10 or other facility or agency that provides health care
11 services and that is licensed, accredited, or certified
12 to provide health care items and services under ap-
13 plicable State law.

14 (7) NETWORK.—The term “network” means,
15 with respect to a group health plan or health insur-
16 ance issuer offering health insurance coverage, the
17 participating health care professionals and providers
18 through whom the plan or issuer provides health
19 care items and services to participants, beneficiaries,
20 or enrollees.

21 (8) NONPARTICIPATING.—The term “non-
22 participating” means, with respect to a health care
23 provider that provides health care items and services
24 to a participant, beneficiary, or enrollee under group
25 health plan or health insurance coverage, a health

1 care provider that is not a participating health care
2 provider with respect to such items and services.

3 (9) PARTICIPATING.—The term “participating”
4 means, with respect to a health care provider that
5 provides health care items and services to a partici-
6 pant, beneficiary, or enrollee under group health
7 plan or health insurance coverage offered by a
8 health insurance issuer, a health care provider that
9 furnishes such items and services under a contract
10 or other arrangement with the plan or issuer.

11 (10) PHYSICIAN.—The term “physician” means
12 an allopathic or osteopathic physician.

13 (11) PRACTICING PHYSICIAN.—The term “prac-
14 ticing physician” means a physician who is licensed
15 in the State in which the physician furnishes profes-
16 sional services and who provides professional services
17 to individual patients on average at least two full
18 days per week.

19 (12) PRIOR AUTHORIZATION.—The term “prior
20 authorization” means the process of obtaining prior
21 approval from a health insurance issuer or group
22 health plan for the provision or coverage of medical
23 services.

1 **SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUC-**
2 **TION.**

3 (a) CONTINUED APPLICABILITY OF STATE LAW
4 WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

5 (1) IN GENERAL.—Subject to paragraph (2),
6 this title shall not be construed to supersede any
7 provision of State law which establishes, implements,
8 or continues in effect any standard or requirement
9 solely relating to health insurance issuers (in connec-
10 tion with group health insurance coverage or other-
11 wise) except to the extent that such standard or re-
12 quirement prevents the application of a requirement
13 of this title.

14 (2) CONTINUED PREEMPTION WITH RESPECT
15 TO GROUP HEALTH PLANS.—Nothing in this title
16 shall be construed to affect or modify the provisions
17 of section 514 of the Employee Retirement Income
18 Security Act of 1974 with respect to group health
19 plans.

20 (b) DEFINITIONS.—For purposes of this section:

21 (1) STATE LAW.—The term “State law” in-
22 cludes all laws, decisions, rules, regulations, or other
23 State action having the effect of law, of any State.
24 A law of the United States applicable only to the
25 District of Columbia shall be treated as a State law
26 rather than a law of the United States.

1 (2) STATE.—The term “State” includes a
2 State, the District of Columbia, the Northern Mar-
3 iana Islands, any political subdivisions of a State or
4 such Islands, or any agency or instrumentality of ei-
5 ther.

6 **SEC. 153. EXCLUSIONS.**

7 (a) NO BENEFIT REQUIREMENTS.—Nothing in this
8 title shall be construed to require a group health plan or
9 a health insurance issuer offering health insurance cov-
10 erage to provide specific benefits under the terms of such
11 plan or coverage, other than those provided under the
12 terms of such plan or coverage.

13 (b) EXCLUSION FROM ACCESS TO CARE MANAGED
14 CARE PROVISIONS FOR FEE-FOR-SERVICE COVERAGE.—

15 (1) IN GENERAL.—The provisions of sections
16 111 through 117 shall not apply to a group health
17 plan or health insurance coverage if the only cov-
18 erage offered under the plan or coverage is fee-for-
19 service coverage (as defined in paragraph (2)).

20 (2) FEE-FOR-SERVICE COVERAGE DEFINED.—

21 For purposes of this subsection, the term “fee-for-
22 service coverage” means coverage under a group
23 health plan or health insurance coverage that—

24 (A) reimburses hospitals, health profes-
25 sionals, and other providers on the basis of a

1 rate determined by the plan or issuer on a fee-
2 for-service basis without placing the provider at
3 financial risk;

4 (B) does not vary reimbursement for such
5 a provider based on an agreement to contract
6 terms and conditions or the utilization of health
7 care items or services relating to such provider;

8 (C) does not restrict the selection of pro-
9 viders among those who are lawfully authorized
10 to provide the covered services and agree to ac-
11 cept the terms and conditions of payment estab-
12 lished under the plan or by the issuer; and

13 (D) for which the plan or issuer does not
14 require prior authorization before providing cov-
15 erage for any services.

16 **SEC. 154. COVERAGE OF LIMITED SCOPE PLANS.**

17 Only for purposes of applying the requirements of
18 this title under sections 2707 and 2753 of the Public
19 Health Service Act and section 714 of the Employee Re-
20 tirement Income Security Act of 1974, section
21 2791(c)(2)(A), and section 733(c)(2)(A) of the Employee
22 Retirement Income Security Act of 1974 shall be deemed
23 not to apply.

1 **SEC. 155. REGULATIONS; COORDINATION; APPLICATION**
2 **UNDER DIFFERENT LAWS.**

3 (a) **REGULATIONS.**—The Secretaries of Health and
4 Human Services, Labor, and the Treasury shall each issue
5 such regulations as may be necessary or appropriate to
6 carry out this title under sections 2707 and 2753 of the
7 Public Health Service Act, under section 714 of the Em-
8 ployee Retirement Income Security Act of 1974, and
9 under section 9813 of the Internal Revenue Code of 1986,
10 respectively. Such Secretaries may promulgate such regu-
11 lations in the form of interim final rules as may be nec-
12 essary to carry out this Act in a timely manner.

13 (b) **ASSURING COORDINATION.**—Such Secretaries
14 shall ensure, through the execution of an interagency
15 memorandum of understanding among such Secretaries,
16 that—

17 (1) regulations, rulings, and interpretations
18 issued by such Secretaries relating to the same mat-
19 ter over which two or more such Secretaries have re-
20 sponsibility under this title (and the amendments
21 made by titles II, III, and IV) are administered so
22 as to have the same effect at all times; and

23 (2) coordination of policies relating to enforcing
24 the same requirements through such Secretaries in
25 order to have a coordinated enforcement strategy

1 that avoids duplication of enforcement efforts and
2 assigns priorities in enforcement.

3 (c) APPLICATION OF SUBTITLE UNDER DIFFERENT
4 LAWS.—The provisions of this subtitle shall be applied—

5 (1) by the Secretary of Health and Human
6 Services under (and only under) title XXVII of the
7 Public Health Service Act (and not under Employee
8 Retirement Income Security Act of 1974 or the In-
9 ternal Revenue Code of 1986);

10 (2) by the Secretary of Labor under (and only
11 under) part 7 of subtitle B of title I of the Employee
12 Retirement Income Security Act of 1974 (and not
13 under the Public Health Service Act or the Internal
14 Revenue Code of 1986); and

15 (3) by the Secretary of the Treasury under
16 (and only under) chapter 100 of the Internal Rev-
17 enue Code of 1986 (and not under the Public Health
18 Service Act or the Employee Retirement Income Se-
19 curity Act of 1974).

20 (d) CONSTRUCTION.—Nothing in this subtitle shall
21 be construed as preventing the Congress from providing
22 for different quality care policies for application under the
23 different titles, parts, and chapters referenced in sub-
24 section (c).

1 **TITLE II—APPLICATION OF**
2 **QUALITY CARE STANDARDS**
3 **TO GROUP HEALTH PLANS**
4 **AND HEALTH INSURANCE**
5 **COVERAGE UNDER THE PUB-**
6 **LIC HEALTH SERVICE ACT**

7 **SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND**
8 **GROUP HEALTH INSURANCE COVERAGE.**

9 (a) IN GENERAL.—Subpart 2 of part A of title
10 XXVII of the Public Health Service Act is amended by
11 adding at the end the following new section:

12 **“SEC. 2707. PATIENT PROTECTION STANDARDS.**

13 “(a) IN GENERAL.—Each group health plan shall
14 comply with patient protection requirements under title I
15 of the Health Care Quality and Choice Act of 1999 (as
16 in effect on the date of the enactment of such Act), and
17 each health insurance issuer shall comply with patient pro-
18 tection requirements under such title with respect to group
19 health insurance coverage it offers, and such requirements
20 shall be deemed to be incorporated into this subsection.

21 “(b) NOTICE.—A group health plan shall comply with
22 the notice requirement under section 711(d) of the Em-
23 ployee Retirement Income Security Act of 1974 (as in ef-
24 fect on the date of the enactment of the Health Care Qual-
25 ity and Choice Act of 1999) with respect to the require-

1 ments referred to in subsection (a) and a health insurance
 2 issuer shall comply with such notice requirement as if such
 3 section applied to such issuer and such issuer were a
 4 group health plan.”.

5 (b) CONFORMING AMENDMENT.—Section
 6 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A))
 7 is amended by inserting “(other than section 2707)” after
 8 “requirements of such subparts”.

9 **SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSUR-**
 10 **ANCE COVERAGE.**

11 Part B of title XXVII of the Public Health Service
 12 Act is amended by inserting after section 2752 the fol-
 13 lowing new section:

14 **“SEC. 2753. PATIENT PROTECTION STANDARDS.**

15 “(a) IN GENERAL.—Each health insurance issuer
 16 shall comply with patient protection requirements under
 17 title I of the Health Care Quality and Choice Act of 1999
 18 (as in effect on the date of the enactment of such Act)
 19 with respect to individual health insurance coverage it of-
 20 fers, and such requirements shall be deemed to be incor-
 21 porated into this subsection.

22 “(b) NOTICE.—A health insurance issuer under this
 23 part shall comply with the notice requirement under sec-
 24 tion 711(d) of the Employee Retirement Income Security
 25 Act of 1974 with respect to the requirements of such title

1 as if such section applied to such issuer and such issuer
 2 were a group health plan.”.

3 **TITLE III—AMENDMENTS TO**
 4 **THE EMPLOYEE RETIREMENT**
 5 **INCOME SECURITY ACT OF**
 6 **1974**

7 **SEC. 301. APPLICATION OF PATIENT PROTECTION STAND-**
 8 **ARDS TO GROUP HEALTH PLANS AND GROUP**
 9 **HEALTH INSURANCE COVERAGE UNDER THE**
 10 **EMPLOYEE RETIREMENT INCOME SECURITY**
 11 **ACT OF 1974.**

12 (a) IN GENERAL.—Subpart B of part 7 of subtitle
 13 B of title I of the Employee Retirement Income Security
 14 Act of 1974 is amended by adding at the end the following
 15 new section:

16 **“SEC. 714. PATIENT PROTECTION STANDARDS.**

17 “A group health plan (and a health insurance issuer
 18 offering group health insurance coverage in connection
 19 with such a plan) shall comply with the requirements of
 20 title I of the Health Care Quality and Choice Act of 1999
 21 (as in effect as of the date of the enactment of such Act),
 22 and such requirements shall be deemed to be incorporated
 23 into this section.”.

24 (b) SATISFACTION OF ERISA CLAIMS PROCEDURE
 25 REQUIREMENT.—Section 503 of such Act (29 U.S.C.

1 1133) is amended by inserting “(a)” after “SEC. 503.”
 2 and by adding at the end the following new subsection:

3 “(b) In the case of a group health plan (as defined
 4 in section 733) compliance with the requirements of sub-
 5 title A of title I of the Health Care Quality and Choice
 6 Act of 1999 (as in effect on the date of the enactment
 7 of such Act) in the case of a claims denial shall be deemed
 8 compliance with subsection (a) with respect to such claims
 9 denial.”.

10 (c) CONFORMING AMENDMENTS.—(1) Section 732(a)
 11 of such Act (29 U.S.C. 1185(a)) is amended by striking
 12 “section 711” and inserting “sections 711 and 714”.

13 (2) The table of contents in section 1 of such Act
 14 is amended by inserting after the item relating to section
 15 713 the following new item:

“Sec. 714. Patient protection standards.”.

16 **SEC. 302. AVAILABILITY OF COURT REMEDIES.**

17 (a) IN GENERAL.—Section 502 of the Employee Re-
 18 tirement Income Security Act of 1974 (29 U.S.C. 1132)
 19 is amended by adding at the end the following new sub-
 20 section:

21 “(n) CAUSE OF ACTION RELATING TO PROVISION OF
 22 HEALTH BENEFITS.—

23 “(1) IN GENERAL.—In any case in which—

24 “(A) a person who is a fiduciary of a
 25 group health plan, a health insurance issuer of-

1 fering health insurance coverage in connection
2 with the plan, or an agent of the plan or plan
3 sponsor and who, under the plan, has authority
4 to make final decisions under section 102 of the
5 Health Care Quality and Choice Act of 1999—

6 “(i) fails to exercise ordinary care in
7 making an incorrect determination in the
8 case of a participant or beneficiary that an
9 item or service is excluded from coverage
10 under the terms of the plan based on the
11 fact that the item or service—

12 “(I) does not meet the require-
13 ments for medical appropriateness or
14 necessity,

15 “(II) would constitute experi-
16 mental treatment or technology (as
17 defined under the plan), or

18 “(III) is not a covered benefit, or

19 “(ii) fails to exercise ordinary care to
20 ensure that—

21 “(I) any denial of claim for bene-
22 fits (within the meaning of section
23 101(f) of the Health Care Quality and
24 Choice Act of 1999), or

1 “(II) any decision by the plan on
2 a request, made by a participant or
3 beneficiary under section 102 or 103
4 of the Health Care Quality and
5 Choice Act of 1999, for a reversal of
6 an earlier decision of the plan,
7 is made and issued to the participant or
8 beneficiary (in such form and manner as
9 may be prescribed in regulations of the
10 Secretary) before the end of the applicable
11 period specified in section 101, 102, or 103
12 of the Health Care Quality and Choice Act
13 of 1999, and

14 “(B) such failure is the proximate cause of
15 personal injury to, or wrongful death of, the
16 participant or beneficiary,

17 such person shall be liable to the participant or ben-
18 eficiary (or the estate of such participant or bene-
19 ficiary) for economic and noneconomic damages in
20 connection with such failure and such injury or
21 death (subject to paragraph (10)).

22 For purposes of this subsection, the term ‘final deci-
23 sion’ means, with respect to a group health plan, a
24 final decision of the plan under section 102 of the
25 Health Care Quality and Choice Act of 1999.

1 “(2) ORDINARY CARE.—For purposes of this
2 subsection, the term ‘ordinary care’ means the care,
3 skill, prudence, and diligence under the cir-
4 cumstances then prevailing that a prudent individual
5 acting in a like capacity and familiar with such mat-
6 ters would use in the conduct of an enterprise of a
7 like character and with like aims.

8 “(3) PERSONAL INJURY.—For purposes of this
9 subsection, the term ‘personal injury’ means a phys-
10 ical injury and includes a physical injury arising out
11 of a failure to treat a mental illness or disease.

12 “(4) EXCEPTION FOR EMPLOYERS AND OTHER
13 PLAN SPONSORS.—

14 “(A) IN GENERAL.—Subject to subpara-
15 graph (B), paragraph (1) does not authorize—

16 “(i) any cause of action against an
17 employer or other plan sponsor maintain-
18 ing the group health plan (or against an
19 employee of such an employer or sponsor
20 acting within the scope of employment), or

21 “(ii) a right of recovery or indemnity
22 by a person against an employer or other
23 plan sponsor (or such an employee) for
24 damages assessed against the person pur-

1 suant to a cause of action under paragraph
2 (1).

3 “(B) SPECIAL RULE.—Subparagraph (A)
4 shall not preclude any cause of action described
5 in paragraph (1) commenced against an em-
6 ployer or other plan sponsor (or against an em-
7 ployee of such an employer or sponsor acting
8 within the scope of employment), but only if—

9 “(i) such action is based on the direct
10 participation of the employer or other plan
11 sponsor (or employee of the employer or
12 plan sponsor) in the final decision of the
13 plan with respect to a specific participant
14 or beneficiary on a claim for benefits cov-
15 ered under the plan or health insurance
16 coverage in the case at issue; and

17 “(ii) the decision on the claim resulted
18 in personal injury to, or the wrongful
19 death of, such participant or beneficiary.

20 “(C) DIRECT PARTICIPATION.—For pur-
21 poses of this subsection, in determining whether
22 an employer or other plan sponsor (or employee
23 of an employer or other plan sponsor) is en-
24 gaged in direct participation in the final deci-
25 sion of the plan on a claim, the employer or

1 plan sponsor (or employee) shall not be con-
2 strued to be engaged in such direct participa-
3 tion (and to be liable for any damages whatso-
4 ever) because of—

5 “(i) any participation by the employer
6 or other plan sponsor (or employee) in the
7 selection of the group health plan or health
8 insurance coverage involved or the third
9 party administrator or other agent;

10 “(ii) any engagement by the employer
11 or other plan sponsor (or employee) in any
12 cost-benefit analysis undertaken in connec-
13 tion with the selection of, or continued
14 maintenance of, the plan or coverage in-
15 volved;

16 “(iii) any decision to increase or de-
17 crease coverage or benefits affecting all
18 plan participants or beneficiaries made in
19 the initial purchase or regular renewal of
20 coverage by the employer or plan sponsor
21 (or employee);

22 “(iv) any action by an agent of the
23 employer or plan sponsor in making such
24 a final decision on behalf of such employer
25 or plan sponsor;

1 “(v) any decision by an employer or
2 plan sponsor (or employee) or agent acting
3 on behalf of an employer or plan sponsor
4 either to authorize coverage for, or to in-
5 tercede or not to intercede as an advocate
6 for or on behalf of, any specific participant
7 or beneficiary (or group of participants or
8 beneficiaries) under the plan; or

9 “(vi) any other form of decision-
10 making or other conduct performed by the
11 employer or other plan sponsor (or em-
12 ployee) in connection with the plan or cov-
13 erage involved unless it involves the mak-
14 ing of a final decision of the plan con-
15 sisting of a failure described in clause (i)
16 or (ii) of paragraph (1)(A) as to specific
17 participants or beneficiaries who suffer
18 personal injury or wrongful death as a
19 proximate cause of such decision.

20 “(5) REQUIRED DEMONSTRATION OF DIRECT
21 PARTICIPATION.—An action against an employer or
22 plan sponsor (or employee thereof) under this sub-
23 section shall be immediately dismissed—

24 “(A) in the absence of an allegation in the
25 complaint of direct participation by the em-

1 ployer or plan sponsor in the final decision of
2 the plan with respect to a specific participant or
3 beneficiary who suffers personal injury or
4 wrongful death, or

5 “(B) upon a demonstration to the court
6 that such employer or plan sponsor (or em-
7 ployee) did not directly participate in the final
8 decision of the plan.

9 “(6) TREATMENT OF THIRD-PARTY PROVIDERS
10 OF NONDISCRETIONARY ADMINISTRATIVE SERV-
11 ICES.—Paragraph (1) does not authorize any action
12 against any person providing nondiscretionary ad-
13 ministrative services to employers or other plan
14 sponsors.

15 “(7) REQUIREMENT OF EXHAUSTION OF AD-
16 MINISTRATIVE REMEDIES.—

17 “(A) IN GENERAL.—Paragraph (1) applies
18 in the case of any cause of action only if all
19 remedies under section 503 (including remedies
20 under sections 102 and 103 of the Health Care
21 Quality and Choice Act of 1999 made applica-
22 ble under section 714) with respect to such
23 cause of action have been exhausted.

24 “(B) EXTERNAL REVIEW REQUIRED.—For
25 purposes of subparagraph (A), administrative

1 remedies under section 503 shall not be deemed
2 exhausted until available remedies under section
3 103 of the Health Care Quality and Choice Act
4 of 1999 have been elected and are exhausted.

5 “(C) CONSIDERATION OF ADMINISTRATIVE
6 DETERMINATIONS.—Any determinations made
7 under section 102 or 103 of the Health Care
8 Quality and Choice Act of 1999 made while an
9 action under this paragraph is pending shall be
10 given due consideration by the court in such ac-
11 tion.

12 “(8) USE OF EXTERNAL APPEAL ENTITY IN ES-
13 TABLISHING ABSENCE OF PERSONAL INJURY OR
14 CAUSATION IN LITIGATION.—

15 “(A) IN GENERAL.—In any action under
16 this subsection by an individual in which dam-
17 ages are sought on the basis of a personal in-
18 jury to the individual, the defendant may obtain
19 (at its own expense), under procedures similar
20 to procedures applicable under section 103 of
21 the Health Care Quality and Choice Act of
22 1999, a determination by a qualified external
23 appeal entity (as defined in section 103(c)(1) of
24 the Health Care Quality and Choice Act of
25 1999) that has not been involved in any stage

1 of the grievance or appeals process which re-
2 sulted in such action as to—

3 “(i) whether or not such a personal
4 injury has been sustained, or

5 “(ii) whether or not the proximate
6 cause of such injury was the result of the
7 failure of the defendant to exercise ordi-
8 nary care, as described in paragraph
9 (1)(A).

10 “(B) EFFECT OF FINDING IN FAVOR OF
11 DEFENDANT.—If the external appeal entity de-
12 termines that such an injury has not been sus-
13 tained or was not proximately caused by such
14 a failure, such a finding shall be an affirmative
15 defense, the action shall be dismissed forthwith,
16 and all liability based upon the alleged injury
17 shall be precluded.

18 “(9) REBUTTABLE PRESUMPTION.—In the case
19 of any action commenced pursuant to paragraph (1),
20 there shall be a rebuttable presumption in favor of
21 the decision of the external appeal entity rendered
22 upon completion of any review elected under section
23 103 of the Health Care Quality and Choice Act of
24 1999 and such presumption may be overcome only

1 upon a showing of clear and convincing evidence to
2 the contrary.

3 “(10) MAXIMUM NONECONOMIC DAMAGES.—
4 Total liability for noneconomic loss under this sub-
5 section in connection with any failure with respect to
6 any participant or beneficiary may not exceed the
7 greater of—

8 “(A) \$250,000, or

9 “(B) 2 times the amount of economic loss.

10 “(11) PROHIBITION OF AWARD OF PUNITIVE
11 DAMAGES.—

12 “(A) GENERAL RULE.—Except as provided
13 in this paragraph, nothing in this subsection
14 shall be construed as authorizing a cause of ac-
15 tion for punitive, exemplary, or similar dam-
16 ages.

17 “(B) EXCEPTION.—Punitive damages are
18 authorized in any case described in paragraph
19 (1)(A)(ii) in which the plaintiff establishes by
20 clear and convincing evidence that conduct car-
21 ried out by the defendant with a conscious, fla-
22 grant indifference to the rights or safety of oth-
23 ers was the proximate cause of the harm that
24 is the subject of the action and that such con-
25 duct was contrary to the recommendations of

1 an external appeal entity issued in any deter-
2 mination (if any) in such case rendered pursu-
3 ant to section 103 of the Health Care Quality
4 and Choice Act of 1999.

5 “(C) LIMITATION ON AMOUNT.—

6 “(i) IN GENERAL.—The amount of
7 punitive damages that may be awarded in
8 an action described in subparagraph (B)
9 may not exceed the greater of—

10 “(I) 2 times the sum of the
11 amount awarded to the claimant for
12 economic loss; or

13 “(II) \$250,000.

14 “(ii) SPECIAL RULE.—Notwith-
15 standing clause (i), in any action described
16 in subparagraph (B) against an individual
17 whose net worth does not exceed \$500,000
18 or against an owner of an unincorporated
19 business, or any partnership, corporation,
20 association, unit of local government, or
21 organization which has fewer than 25 em-
22 ployees, the punitive damages shall not ex-
23 ceed the lesser of—

24 “(I) 2 times the amount awarded
25 to the claimant for economic loss; or

1 “(II) \$250,000.

2 “(iii) CONTROLLED GROUPS.—

3 “(I) IN GENERAL.—For the pur-
4 pose of determining the applicability
5 of clause (ii) to any employer, in de-
6 termining the number of employees of
7 an employer who is a member of a
8 controlled group, the employees of any
9 person in such group shall be deemed
10 to be employees of the employer.

11 “(II) CONTROLLED GROUP.—For
12 purposes of subclause (I), the term
13 ‘controlled group’ means any group
14 treated as a single employer under
15 subsection (b), (c), (m), or (o) of sec-
16 tion 414 of the Internal Revenue Code
17 of 1986.

18 “(D) EXCEPTION FOR INSUFFICIENT
19 AWARD IN CASES OF EGREGIOUS CONDUCT.—

20 “(i) DETERMINATION BY COURT.—If
21 the court makes a determination, after
22 considering each of the factors in subpara-
23 graph (E), that the application of subpara-
24 graph (B) would result in an award of pu-
25 nitive damages that is insufficient to pun-

1 ish the egregious conduct of the defendant
2 against whom the punitive damages are to
3 be awarded or to deter such conduct in the
4 future, the court shall determine the addi-
5 tional amount of punitive damages (re-
6 ferred to in this subparagraph as the ‘addi-
7 tional amount’) in excess of the amount
8 determined in accordance with subpara-
9 graph (B) to be awarded against the de-
10 fendant in a separate proceeding in accord-
11 ance with this subparagraph.

12 “(ii) REQUIREMENTS FOR AWARDING
13 ADDITIONAL AMOUNT.—If the court
14 awards an additional amount pursuant to
15 this subparagraph, the court shall state its
16 reasons for setting the amount of the addi-
17 tional amount in findings of fact and con-
18 clusions of law.

19 “(E) FACTORS FOR CONSIDERATION IN
20 CASES OF EGREGIOUS CONDUCT.—In any pro-
21 ceeding under subparagraph (D), the matters to
22 be considered by the court shall include (but
23 are not limited to)—

24 “(i) the extent to which the defendant
25 acted with actual malice;

1 “(ii) the likelihood that serious harm
2 would arise from the conduct of the de-
3 fendant;

4 “(iii) the degree of the awareness of
5 the defendant of that likelihood;

6 “(iv) the profitability of the mis-
7 conduct to the defendant;

8 “(v) the duration of the misconduct
9 and any concurrent or subsequent conceal-
10 ment of the conduct by the defendant;

11 “(vi) the attitude and conduct of the
12 defendant upon the discovery of the mis-
13 conduct and whether the misconduct has
14 terminated;

15 “(vii) the financial condition of the
16 defendant; and

17 “(viii) the cumulative deterrent effect
18 of other losses, damages, and punishment
19 suffered by the defendant as a result of the
20 misconduct, reducing the amount of puni-
21 tive damages on the basis of the economic
22 impact and severity of all measures to
23 which the defendant has been or may be
24 subjected, including—

1 “(I) compensatory and punitive
2 damage awards to similarly situated
3 claimants;

4 “(II) the adverse economic effect
5 of stigma or loss of reputation;

6 “(III) civil fines and criminal and
7 administrative penalties; and

8 “(IV) stop sale, cease and desist,
9 and other remedial or enforcement or-
10 ders.

11 “(F) APPLICATION BY COURT.—This para-
12 graph shall be applied by the court and, in the
13 case of a trial by jury, application of this para-
14 graph shall not be disclosed to the jury. Noth-
15 ing in this paragraph shall authorize the court
16 to enter an additional award of punitive dam-
17 ages in excess of the amount of the jury’s initial
18 award of punitive damages.

19 “(G) LIMITATION ON PUNITIVE DAM-
20 AGES.—No person shall be liable for punitive,
21 exemplary, or similar damages in an action
22 under this subsection based on any failure de-
23 scribed in paragraph (1) if such failure was in
24 compliance with the recommendations of an ex-
25 ternal appeal entity issued in a determination

1 under section 103 of the Health Care Quality
2 and Choice Act of 1999.

3 “(H) BIFURCATION AT REQUEST OF ANY
4 PARTY.—

5 “(i) IN GENERAL.—At the request of
6 any party the trier of fact in any action
7 that is subject to this paragraph shall con-
8 sider in a separate proceeding, held subse-
9 quent to the determination of the amount
10 of compensatory damages, whether puni-
11 tive damages are to be awarded for the
12 harm that is the subject of the action and
13 the amount of the award.

14 “(ii) INADMISSIBILITY OF EVIDENCE
15 RELATIVE ONLY TO A CLAIM OF PUNITIVE
16 DAMAGES IN A PROCEEDING CONCERNING
17 COMPENSATORY DAMAGES.—If any party
18 requests a separate proceeding under
19 clause (i), in a proceeding to determine
20 whether the claimant may be awarded
21 compensatory damages, any evidence, ar-
22 gument, or contention that is relevant only
23 to the claim of punitive damages, as deter-
24 mined by applicable State law, shall be in-
25 admissible.

1 “(12) LIMITATION OF ACTION.—Paragraph (1)
2 shall not apply in connection with any action com-
3 menced after the later of—

4 “(A) 1 year after (i) the date of the last
5 action which constituted a part of the failure,
6 or (ii) in the case of an omission, the latest
7 date on which the fiduciary could have cured
8 the failure, or

9 “(B) 1 year after the earliest date on
10 which the plaintiff first knew, or reasonably
11 should have known, of the bodily injury result-
12 ing from the failure.

13 “(13) COORDINATION WITH FIDUCIARY RE-
14 QUIREMENTS.—A fiduciary shall not be treated as
15 failing to meet any requirement of part 4 solely by
16 reason of any action taken by a fiduciary which con-
17 sists of full compliance with the reversal under sec-
18 tion 103 of the Health Care Quality and Choice Act
19 of 1999 of a denial of claim for benefits (within the
20 meaning of section 101(f) of such Act).

21 “(14) CONSTRUCTION.—Nothing in this sub-
22 section shall be construed as authorizing a cause of
23 action for the failure to provide an item or service
24 which is not covered under the group health plan in-
25 volved.

1 “(15) PROTECTION OF MEDICAL MALPRACTICE
2 AND SIMILAR ACTIONS UNDER STATE LAW.—This
3 subsection shall not be construed to preclude any ac-
4 tion under State law (as defined in section
5 514(c)(1)) with respect to the duty (if any) under
6 such State law imposed on any person to exercise a
7 specified standard of care when making a health
8 care treatment decision where medical services are
9 provided by such person and the decision affects the
10 quality of care or treatment provided or received.

11 “(16) REFERENCES TO THE HEALTH CARE
12 QUALITY AND CHOICE ACT OF 1999.—Any reference
13 in this subsection to any provision of the Health
14 Care Quality and Choice Act of 1999 shall be
15 deemed a reference to such provision as in effect on
16 the date of the enactment of such Act.”.

17 (b) CONFORMING AMENDMENT.—Section
18 502(a)(1)(A) of such Act (29 U.S.C. 1132(a)(1)(A)) is
19 amended by inserting “or (n)” after “subsection (c)”.

20 (c) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to acts and omissions (from which
22 a cause of action arises) occurring on or after the date
23 of the enactment of this Act.

1 **SEC. 303. AVAILABILITY OF BINDING ARBITRATION.**

2 (a) IN GENERAL.—Section 503 of the Employee Re-
3 tirement Income Security Act of 1974 (as amended by the
4 preceding provisions of this Act) is amended further—

5 (1) in subsection (a), by inserting “IN GEN-
6 ERAL.—” after “(a)”;

7 (2) in subsection (b), by striking “(b) In the
8 case” and inserting the following:

9 “(b) GROUP HEALTH PLANS.—

10 “(1) IN GENERAL.—In the case”; and

11 (3) by adding at the end of subsection (b) the
12 following:

13 “(2) BINDING ARBITRATION PERMITTED AS AL-
14 TERNATIVE MEANS OF DISPUTE RESOLUTION.—

15 “(A) IN GENERAL.—A group health plan
16 shall not be treated as failing to meet the re-
17 quirements of the preceding provisions of this
18 section relating to review of any adverse cov-
19 erage decision rendered by or under the plan,
20 if—

21 “(i) in lieu of the procedures other-
22 wise provided under the plan in accordance
23 with such provisions and in lieu of any
24 subsequent review of the matter by a court
25 under section 502—

1 “(I) the aggrieved participant or
2 beneficiary elects in the request for
3 the review a procedure by which the
4 dispute is resolved by binding arbitra-
5 tion which is available under the plan
6 with respect to similarly situated par-
7 ticipants and beneficiaries and which
8 meets the requirements of subpara-
9 graph (B); or

10 “(II) in the case of any such plan
11 or portion thereof which is established
12 and maintained pursuant to a bona
13 fide collective bargaining agreement,
14 the plan provides for a procedure by
15 which such disputes are resolved by
16 means of binding arbitration which
17 meets the requirements of subpara-
18 graph (B); and

19 “(ii) the additional requirements of
20 subparagraph (B) are met.

21 “(B) ADDITIONAL REQUIREMENTS.—The
22 Secretary shall prescribe by regulation require-
23 ments for arbitration procedures under this
24 paragraph, including at least the following re-
25 quirements:

1 “(i) ARBITRATION PANEL.—The arbi-
2 tration shall be conducted by an arbitra-
3 tion panel meeting the requirements of
4 subparagraph (C).

5 “(ii) FAIR PROCESS; DE NOVO DETER-
6 MINATION.—The procedure shall provide
7 for a fair, de novo determination.

8 “(iii) OPPORTUNITY TO SUBMIT EVI-
9 DENCE, HAVE REPRESENTATION, AND
10 MAKE ORAL PRESENTATION.—Each party
11 to the arbitration procedure—

12 “(I) may submit and review evi-
13 dence related to the issues in dispute;

14 “(II) may use the assistance or
15 representation of one or more individ-
16 uals (any of whom may be an attor-
17 ney); and

18 “(III) may make an oral presen-
19 tation.

20 “(iv) PROVISION OF INFORMATION.—
21 The plan shall provide timely access to all
22 its records relating to the matters under
23 arbitration and to all provisions of the plan
24 relating to such matters.

1 “(v) TIMELY DECISIONS.—A deter-
2 mination by the arbitration panel on the
3 decision shall—

4 “(I) be made in writing;

5 “(II) be binding on the parties;

6 and

7 “(III) be made in accordance
8 with the medical exigencies of the case
9 involved.

10 “(C) ARBITRATION PANEL.—

11 “(i) IN GENERAL.—Arbitrations com-
12 menced pursuant to this paragraph shall
13 be conducted by a panel of arbitrators se-
14 lected by the parties made up of 3 individ-
15 uals, including at least one practicing phy-
16 sician and one practicing attorney.

17 “(ii) QUALIFICATIONS.—Any indi-
18 vidual who is a member of an arbitration
19 panel shall meet the following require-
20 ments:

21 “(I) There is no real or apparent
22 conflict of interest that would impede
23 the individual conducting arbitration
24 independent of the plan and meets the

1 independence requirements of clause
2 (iii).

3 “(II) The individual has suffi-
4 cient medical or legal expertise to con-
5 duct the arbitration for the plan on a
6 timely basis.

7 “(III) The individual has appro-
8 priate credentials and has attained
9 recognized expertise in the applicable
10 medical or legal field.

11 “(IV) The individual was not in-
12 volved in the initial adverse coverage
13 decision or any other review thereof.

14 “(iii) INDEPENDENCE REQUIRE-
15 MENTS.—An individual described in clause
16 (ii) meets the independence requirements
17 of this clause if—

18 “(I) the individual is not affili-
19 ated with any related party,

20 “(II) any compensation received
21 by such individual in connection with
22 the binding arbitration procedure is
23 reasonable and not contingent on any
24 decision rendered by the individual,

1 “(III) under the terms of the
2 plan, the plan has no recourse against
3 the individual or entity in connection
4 with the binding arbitration proce-
5 dure, and

6 “(IV) the individual does not oth-
7 erwise have a conflict of interest with
8 a related party as determined under
9 such regulations as the Secretary may
10 prescribe.

11 “(iv) RELATED PARTY.—For purposes
12 of clause (iii), the term ‘related party’
13 means—

14 “(I) the plan or any health insur-
15 ance issuer offering health insurance
16 coverage in connection with the plan
17 (or any officer, director, or manage-
18 ment employee of such plan or issuer),

19 “(II) the physician or other med-
20 ical care provider that provided the
21 medical care involved in the coverage
22 decision,

23 “(III) the institution at which
24 the medical care involved in the cov-
25 erage decision is provided,

1 “(IV) the manufacturer of any
2 drug or other item that was included
3 in the medical care involved in the
4 coverage decision, or

5 “(V) any other party determined
6 under such regulations as the Sec-
7 retary may prescribe to have a sub-
8 stantial interest in the coverage deci-
9 sion .

10 “(iv) AFFILIATED.—For purposes of
11 clause (iii), the term ‘affiliated’ means, in
12 connection with any entity, having a famil-
13 ial, financial, or professional relationship
14 with, or interest in, such entity.

15 “(D) DECISIONS.—

16 “(i) IN GENERAL.—Decisions ren-
17 dered by the arbitration panel shall be
18 binding on all parties to the arbitration
19 and shall be enforceable under section 502
20 as if the terms of the decision were the
21 terms of the plan, except that the court
22 may vacate any award made pursuant to
23 the arbitration for any cause described in
24 paragraph (1), (2), (3), (4), or (5) of sec-
25 tion 10(a) of title 9, United States Code.

1 “(ii) ALLOWABLE REMEDIES.—The
 2 remedies which may be implemented by the
 3 arbitration panel shall consist of those
 4 remedies which would be available in an
 5 action timely commenced by a participant
 6 or beneficiary under section 502 after ex-
 7 haustion of administrative remedies.”.

8 (b) EFFECTIVE DATE.—The amendment made by
 9 this section shall apply to adverse coverage decisions ini-
 10 tially rendered by group health plans on or after the date
 11 of the enactment of this Act.

12 **TITLE IV—APPLICATION TO**
 13 **GROUP HEALTH PLANS**
 14 **UNDER THE INTERNAL REV-**
 15 **ENUE CODE OF 1986.**

16 **SEC. 401. AMENDMENTS TO THE INTERNAL REVENUE CODE**
 17 **OF 1986.**

18 Subchapter B of chapter 100 of the Internal Revenue
 19 Code of 1986 is amended—

20 (1) in the table of sections, by inserting after
 21 the item relating to section 9812 the following new
 22 item:

 “Sec. 9813. Standard relating to Health Care Quality and
 Choice Act.”; and

23 (2) by inserting after section 9812 the fol-
 24 lowing:

1 **“SEC. 9813. STANDARD RELATING TO HEALTH CARE QUAL-**
2 **ITY AND CHOICE ACT.**

3 “A group health plan shall comply with the require-
4 ments of title I of the Health Care Quality and Choice
5 Act of 1999 (as in effect as of the date of the enactment
6 of such Act), and such requirements shall be deemed to
7 be incorporated into this section.”.

8 **TITLE V—EFFECTIVE DATES; CO-**
9 **ORDINATION IN IMPLEMEN-**
10 **TATION**

11 **SEC. 501. EFFECTIVE DATES.**

12 (a) GROUP HEALTH COVERAGE.—

13 (1) IN GENERAL.—Subject to paragraph (2),
14 the amendments made by sections 201(a), 301, and
15 401 (and title I insofar as it relates to such sections)
16 shall apply with respect to group health plans, and
17 health insurance coverage offered in connection with
18 group health plans, for plan years beginning on or
19 after January 1, 2000 (in this section referred to as
20 the “general effective date”) and also shall apply to
21 portions of plan years occurring on and after such
22 date.

23 (2) TREATMENT OF COLLECTIVE BARGAINING
24 AGREEMENTS.—In the case of a group health plan
25 maintained pursuant to 1 or more collective bar-
26 gaining agreements between employee representa-

1 tives and 1 or more employers ratified before the
 2 date of enactment of this Act, the amendments made
 3 by sections 201(a), 301, and 401 (and title I insofar
 4 as it relates to such sections) shall not apply to plan
 5 years beginning before the later of—

6 (A) the date on which the last collective
 7 bargaining agreements relating to the plan ter-
 8 minates (determined without regard to any ex-
 9 tension thereof agreed to after the date of en-
 10 actment of this Act), or

11 (B) the general effective date.

12 For purposes of subparagraph (A), any plan amend-
 13 ment made pursuant to a collective bargaining
 14 agreement relating to the plan which amends the
 15 plan solely to conform to any requirement added by
 16 this Act shall not be treated as a termination of
 17 such collective bargaining agreement.

18 (b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—

19 The amendments made by section 202 shall apply with
 20 respect to individual health insurance coverage offered,
 21 sold, issued, renewed, in effect, or operated in the indi-
 22 vidual market on or after the general effective date.

23 **SEC. 502. COORDINATION IN IMPLEMENTATION.**

24 The Secretary of Labor, the Secretary of Health and
 25 Human Services, and the Secretary of the Treasury shall

1 ensure, through the execution of an interagency memo-
 2 randum of understanding among such Secretaries, that—

3 (1) regulations, rulings, and interpretations
 4 issued by such Secretaries relating to the same mat-
 5 ter over which both Secretaries have responsibility
 6 under the provisions of this Act (and the amend-
 7 ments made thereby) are administered so as to have
 8 the same effect at all times; and

9 (2) coordination of policies relating to enforcing
 10 the same requirements through such Secretaries in
 11 order to have a coordinated enforcement strategy
 12 that avoids duplication of enforcement efforts and
 13 assigns priorities in enforcement.

14 **TITLE VI—OTHER PROVISIONS**

15 **SEC. 601. HEALTH CARE PAPERWORK SIMPLIFICATION.**

16 (a) ESTABLISHMENT OF PANEL.—

17 (1) ESTABLISHMENT.—There is established a
 18 panel to be known as the Health Care Panel to De-
 19 vise a Uniform Explanation of Benefits (in this sec-
 20 tion referred to as the “Panel”).

21 (2) DUTIES OF PANEL.—

22 (A) IN GENERAL.—The Panel shall devise
 23 a single form for use by third-party health care
 24 payers for the remittance of claims to providers.

1 (B) DEFINITION.—For purposes of this
2 section, the term “third-party health care
3 payer” means any entity that contractually
4 pays health care bills for an individual.

5 (3) MEMBERSHIP.—

6 (A) SIZE AND COMPOSITION.—The Sec-
7 retary of Health and Human Services, in con-
8 sultation with the Majority Leader of the Sen-
9 ate and the Speaker of the House of Represent-
10 atives, shall determine the number of members
11 and the composition of the Panel. Such Panel
12 shall include equal numbers of representatives
13 of private insurance organizations, consumer
14 groups, State insurance commissioners, State
15 medical societies, State hospital associations,
16 and State medical specialty societies.

17 (B) TERMS OF APPOINTMENT.—The mem-
18 bers of the Panel shall serve for the life of the
19 Panel.

20 (C) VACANCIES.—A vacancy in the Panel
21 shall not affect the power of the remaining
22 members to execute the duties of the Panel, but
23 any such vacancy shall be filled in the same
24 manner in which the original appointment was
25 made.

1 (4) PROCEDURES.—

2 (A) MEETINGS.—The Panel shall meet at
3 the call of a majority of its members.

4 (B) FIRST MEETING.—The Panel shall
5 convene not later than 60 days after the date
6 of the enactment of the Health Care Quality
7 and Choice Act of 1999.

8 (C) QUORUM.—A quorum shall consist of
9 a majority of the members of the Panel.

10 (D) HEARINGS.—For the purpose of car-
11 rying out its duties, the Panel may hold such
12 hearings and undertake such other activities as
13 the Panel determines to be necessary to carry
14 out its duties.

15 (5) ADMINISTRATION.—

16 (A) COMPENSATION.—Except as provided
17 in subparagraph (B), members of the Panel
18 shall receive no additional pay, allowances, or
19 benefits by reason of their service on the Panel.

20 (B) TRAVEL EXPENSES AND PER DIEM.—
21 Each member of the Panel who is not an officer
22 or employee of the Federal Government shall
23 receive travel expenses and per diem in lieu of
24 subsistence in accordance with sections 5702
25 and 5703 of title 5, United States Code.

1 (C) CONTRACT AUTHORITY.—The Panel
2 may contract with and compensate government
3 and private agencies or persons for items and
4 services, without regard to section 3709 of the
5 Revised Statutes (41 U.S.C. 5).

6 (D) USE OF MAILS.—The Panel may use
7 the United States mails in the same manner
8 and under the same conditions as Federal agen-
9 cies and shall, for purposes of the frank, be
10 considered a commission of Congress as de-
11 scribed in section 3215 of title 39, United
12 States Code.

13 (E) ADMINISTRATIVE SUPPORT SERV-
14 ICES.—Upon the request of the Panel, the Sec-
15 retary of Health and Human Services shall pro-
16 vide to the Panel on a reimbursable basis such
17 administrative support services as the Panel
18 may request.

19 (6) SUBMISSION OF FORM.—Not later than 2
20 years after the first meeting, the Panel shall submit
21 a form to the Secretary of Health and Human Serv-
22 ices for use by third-party health care payers.

23 (7) TERMINATION.—The Panel shall terminate
24 on the day after submitting its the form under para-
25 graph (6).

1 (b) REQUIREMENT FOR USE OF FORM BY THIRD-
2 PARTY CARE PAYERS.—A third-party health care payer
3 shall be required to use the form devised under subsection
4 (a) for plan years beginning on or after 5 years following
5 the date of the enactment of this Act.

6 **SEC. 602. PROTECTION FOR CERTAIN INFORMATION.**

7 (a) PROTECTION OF CERTAIN INFORMATION.—Not-
8 withstanding any other provision of Federal or State law,
9 health care response information shall be exempt from any
10 disclosure requirement (regardless of whether the require-
11 ment relates to subpoenas, discovery, introduction of evi-
12 dence, testimony, or any other form of disclosure), in con-
13 nection with a civil or administrative proceeding under
14 Federal or State law, to the same extent as information
15 developed by a health care provider with respect to any
16 of the following:

- 17 (1) Peer review.
- 18 (2) Utilization review.
- 19 (3) Quality management or improvement.
- 20 (4) Quality control.
- 21 (5) Risk management.
- 22 (6) Internal review for purposes of reducing
23 mortality, morbidity, or for improving patient care
24 or safety.

1 (b) NO WAIVER OF PROTECTION THROUGH INTER-
2 ACTION WITH ACCREDITING BODY.—Notwithstanding
3 any other provision of Federal or State law, the protection
4 of health care response information from disclosure pro-
5 vided under subsection (a) shall not be deemed to be modi-
6 fied or in any way waived by—

7 (1) the development of such information in con-
8 nection with a request or requirement of an accred-
9 iting body; or

10 (2) the transfer of such information to an ac-
11 crediting body.

12 (c) DEFINITIONS.—For purposes of this section:

13 (1) ACCREDITING BODY.—The term “accred-
14 iting body” means a national, not-for-profit organi-
15 zation that—

16 (A) accredits health care providers; and

17 (B) is recognized as an accrediting body by
18 statute or by a Federal or State agency that
19 regulates health care providers.

20 (2) HEALTH CARE RESPONSE INFORMATION.—

21 The term “health care response information” means
22 information (including any data, report, record,
23 memorandum, analysis, statement, or other commu-
24 nication) developed by, or on behalf of, a health care

1 provider in response to a serious, adverse, patient
2 related event—

3 (A) during the course of analyzing or
4 studying the event and its causes; and

5 (B) for the purposes of—

6 (i) reducing mortality or morbidity; or

7 (ii) improving patient care or safety

8 (including the provider’s notification to an
9 accrediting body and the provider’s plans
10 of action in response to such event).

11 (3) HEALTH CARE PROVIDER.—The term
12 “health care provider” means a person, who with re-
13 spect to a specific item of protected health informa-
14 tion, receives, creates, uses, maintains, or discloses
15 the information while acting in whole or in part in
16 the capacity of—

17 (A) a person who is licensed, certified, reg-
18 istered, or otherwise authorized by Federal or
19 State law to provide an item or service that
20 constitutes health care in the ordinary course of
21 business, or practice of a profession;

22 (B) a Federal, State, or employer-spon-
23 sored or any other privately-sponsored program
24 that directly provides items or services that con-
25 stitute health care to beneficiaries; or

1 (C) an officer or employee of a person de-
2 scribed in subparagraph (A) or (B).

3 (4) STATE.—The term “State” includes a
4 State, the District of Columbia, the Northern Mar-
5 iana Islands, any political subdivisions of a State or
6 such Islands, or any agency or instrumentality of ei-
7 ther.

8 (d) EFFECTIVE DATE.—The provisions of this sec-
9 tion are effective on the date of the enactment of this Act.

10 **SEC. 603. MEDICARE COMPETITIVE PRICING DEMONSTRA-**
11 **TION PROJECT.**

12 (a) FINDING.—The Congress finds that imple-
13 menting competitive pricing in the medicare program
14 under title XVIII of the Social Security Act is an impor-
15 tant goal.

16 (b) PROHIBITION ON IMPLEMENTATION OF PROJECT
17 IN CERTAIN AREAS.—Notwithstanding subsection (b) of
18 section 4011 of the Balanced Budget Act of 1997 (Public
19 Law 105–33)), the Secretary of Health and Human Serv-
20 ices may not implement the Medicare Competitive Pricing
21 Demonstration Project (operated by the Secretary of
22 Health and Human Services pursuant to such section) in
23 Kansas City, Missouri or Kansas City, Kansas, or in any
24 area in Arizona.

1 (c) MORATORIUM ON IMPLEMENTATION OF PROJECT
2 IN ANY AREA UNTIL JANUARY, 1, 2001.—Notwith-
3 standing any provision of section 4011 of the Balanced
4 Budget Act of 1997 (Public Law 105–33)), the Secretary
5 of Health and Human Services may not implement the
6 Medicare Competitive Pricing Demonstration Project in
7 any area before January 1, 2001.

8 (d) STUDY AND REPORT TO CONGRESS.—

9 (1) STUDY.—The Secretary of Health and
10 Human Services, in conjunction with the Competi-
11 tive Pricing Advisory Committee, shall conduct a
12 study on the different approaches of implementing
13 the Medicare Competitive Pricing Demonstration
14 Project on a voluntary basis.

15 (2) REPORT.—Not later than June 30, 2000,
16 the Secretary of Health and Human Services shall
17 submit a report to Congress which shall contain a
18 detailed description of the study conducted under
19 paragraph (1), together with the recommendations
20 of the Secretary and the Competitive Pricing Advi-
21 sory Committee regarding the implementation of the
22 Medicare Competitive Pricing Demonstration
23 Project.

○